MEDICAL RELEASE FORM

HOPE requires that all outreach team members and volunteers carry medical insurance that covers them while they are traveling abroad. If your current insurance does not cover you for such occasions, then you must purchase additional coverage.

Insurance Information:

Company: ____

Policy Type: ______________________________________ Policy #: ______________________________________

Medical Information:

Name of Family Physician: __________________________ Phone #: ______________________________________

Emergency Contact: ________________________________ Phone #: ______________________________________

Relationship to Participant: _________________________ Email: ____

Illnesses or Injuries: (Check all that apply)

Chronic or Recurring Illness: Asthma ____ Ear Infection ____ Epilepsy ____ Other _____________________

Other Health Conditions: Sleep Walking ____ Glasses ____ Contact Lenses ____ Special Dietary Regime ____

Motion Sickness ____ Other _____________________

Are you currently under the care of a doctor for any condition? Yes ____ No ____
(If yes, please give details)

Will you be bringing any prescription medication(s) on this outreach? Yes ____ No ____

(If yes, please indicate name(s) of the medication(s) and for what condition(s))

Are you allergic to any medications? Yes ____ No ____
(If yes, please give details)

Do you have any food allergies? Yes ____ No ____
(If yes, please give details)

Do you have any physical impairments or health conditions which require special attention? Yes ____ No ____
(If yes, please give details)

How would you rate your health? Excellent ____ Good ____ Fair ____ Poor ____

Please indicate any useful information to the outreach leader(s) in relation to any of these health conditions. Also, indicate any activities to be encouraged or restricted. Use another sheet if necessary.

Statement: I understand that I am responsible for my own insurance, health and belongings. I understand that Hope for the Nations is not responsible for the cost of my medical care or any loss or damage that I incur during or as a result of my travel and time on this outreach. I undertake this outreach at my own risk.

I hereby grant permission for the performance of any emergency treatment that may be required in the case of an accident or illness wherein I am rendered unconscious or unable to approve the required medical treatment. Or as a parent/guardian, I give permission for said treatment to be given to my minor child.

Name of Participant (print)	Signature	Date (d/m/y)
Name of Participant's Parent/Guardian	Signature	Date (d/m/y)

"NGO in Special Consultative Status with the Economic and Social Council of the United Nations"

222 - 1889 Springfield Road, Kelowna, B.C. Canada, V1Y 5V5 Tel. (250) 712-2007 Fax (250) 862-2942

Email: volunteers@hopeforthenations.com