

## Heal Ministries Release Form – Minor Participants

Project Location: _____	Participant's Name: _____
Project Dates: _____	Birth Date: _____
Church: _____	Address: _____
Church City, State: _____	City, State, Zip: _____
	Home Phone: _____
Alternate Emergency Contact and Phone: _____	

### What We Require

**US Project Locations:** Coverage includes accidents only; it does not cover sickness/illness. Each participant is required to have his/her own primary medical insurance for sickness.

**International Project Locations:** Coverage includes both accidents and sickness. However, because this is a secondary coverage, each participant is still required to have his/her own primary medical insurance for sickness.

A Participant, who does not have a primary medical insurance policy, must apply for supplementary coverage.

### Please indicate the status of your primary medical insurance:

U.S. Projects:

- I do have a primary medical insurance policy.
- I do not have primary medical insurance but I am applying for supplementary coverage.

International Projects:

- I do have a primary insurance policy, and I have confirmed that it will cover me while outside the U.S. on this project.
- I do have primary medical insurance, but it will **not** cover me outside the U.S.; I am applying for supplemental coverage.
- I do not have a primary medical insurance; I am applying for supplementary coverage.

**Permission to Travel:**

As a parent of guardian, I give my permission for (name) \_\_\_\_\_ to travel to (location) \_\_\_\_\_ to participate in CPC's Short-Term Missions Program on the following date (from): \_\_\_\_\_ (to): \_\_\_\_\_, 20\_\_.

Signature of Father: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Mother: \_\_\_\_\_ Date: \_\_\_\_\_

Other Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Immunizations and Medical Consent:**

My child has had all routine immunizations (dT-diphtheria, tetanus, MMR-measles, mumps, rubella and polio) \_\_\_Yes \_\_\_No

My child has had a tetanus booster within the past 10 years. \_\_\_Yes \_\_\_No

I have checked with my doctor, the CDC or a travel clinic and am aware of the immunizations recommended and required for the area in which my child will be traveling. \_\_\_Yes \_\_\_No

In the event of a medical emergency, I hereby consent to the necessary and proper treatment, surgery, and/or anesthetic by a licensed physician of health care professional for (name) \_\_\_\_\_.

Signature of Father: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Mother: \_\_\_\_\_ Date: \_\_\_\_\_

Other Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Notarization Required:**

State of \_\_\_\_\_ County of \_\_\_\_\_

Acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20

NOTARY PUBLIC \_\_\_\_\_

Date Commission Expires \_\_\_\_\_