RELEASE FOR MEDICAL EMERGENCY CARE – HONDURAS MISSION TRIP

CENTRAL AMERICAN RELIEF EFFORTS

To whom it may concern:

I hereby give my consent to any emergency facility and physicians to administer necessary treatment to my child/self, _____, in the event of an emergency. I give consent to transport by ambulance if the situation so warrants. In addition, I agree to be financially responsible for any medical expenses incurred by my child/self.

Family Physician's Name: _____ Phone number: _____

Known allergies: _____

Date of last DPT or Tetanus shot: _____

List any other medical or emotional considerations we should be aware of:

_____

_____

Health Insurance Company: _____

Policy Number: _____ Expiration: _____

Beneficiary for Insured: _____ Relationship: _____

Participant's Full Legal Name: _____ Gender:_____

Date of Birth: _____ SSN: _____ Passport Number: _____

Home Country: _____ Phone: _____ Email: _____

Mailing Address: _____

_____ _____

(Signature of Parent, Guardian, or Participant) (Date)