Equip International
Medical Information & Release for 2019

Team Member Name: _____

DOB: _____ Passport #: _____ Country: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Team Leader: _____

Dates of Mission Trip: _____ Team Name: _____

I, _____, will be traveling to Honduras to work with Equip International, to the districts of Comayagua and La Paz. If I need medical attention, I give my team members and the Equip International staff the right to give consent to authorize emergency medical care. It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization release the physician, dentist, person rendering such care at the hospital or institution in which such care is given, Equip International and it's staff, and my team members from any liability resulting from the failure of me signing a consent or authorization to render such care. It is the intent that Equip International staff and team members shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by Equip International staff or team members. I understand that this form is in effect from the departure of our team to our arrival back to our city of departure.

MEDICAL HISTORY INFORMATION: (please use extra pages if necessary)

1. Do you have any current medical conditions or physical limitations? If so, list them.

2. Have you had major surgery in the past 12 months? If so, explain.

3. Do you currently have any mental or emotional conditions Equip International staff should be aware of?

4. Are you presently taking any prescription or non-prescription medicine on a regular basis? If so, list them.

5. Are you allergic to any medication or food? If so, list. Are there special medications, dosages, and instructions for this allergy? If you are allergic to a food, please make the staff aware of this upon your arrival—or before if needed.

Date of Last Tetanus: _____

Team Member's Physician: _____ Phone: _____

Medical Insurance Provider: _____ Phone: _____

Policy Number: _____ Group Number: _____

Who should be contacted in case of emergency?

Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Liability Release: I certify that the information described above is accurate and complete to the best of my knowledge. I understand that each individual is responsible for his/her own insurance coverage during this trip. I hereby release Equip International, their Board of Directors, staff, and any designated individual in charge of the group from any legal or financial responsibility with respect to my personal or my child's participation in or contact with any known or unknown element associated with all activities.

Signature of team member: _____ Date: _____

Signature of parent: _____ Date: _____
(If team member is under the age of 18)