

**MINOR MTW RELEASE FORM (0-17 years)**

**Participant:** Please complete ALL information requested, give completed and notarized form to your team leader.

**Team Leader:** Please review and sign each form; send copy to MTW and take original to the project.

Participant's name: \_\_\_\_\_ Project location: \_\_\_\_\_  
 Date of birth (mm/dd/yyyy): \_\_\_\_\_ Project dates: \_\_\_\_\_  
 Gender (male/female): \_\_\_\_\_ Church name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Church city/state: \_\_\_\_\_  
 City, state, zip: \_\_\_\_\_ Team leader: \_\_\_\_\_  
 Emergency contact name and phone (must not be a trip participant): \_\_\_\_\_

**INSURANCE REQUIREMENTS**

**Each MTW participant is required to have his/her own primary medical insurance.** For international projects, the primary insurance must cover the participant while overseas. Any participant who does not have a primary medical insurance policy must apply for short-term coverage.

**Please indicate the status of your medical insurance coverage:**

- I do have primary medical insurance coverage and I have confirmed that it will cover my child while outside the US on this project. **Insurance Company:** \_\_\_\_\_
- I have primary medical insurance coverage, but it will **not** cover my child outside the US. I have obtained short-term coverage with: \_\_\_\_\_
- I do **not** have primary medical insurance coverage. I have applied for short-term coverage for my child with: \_\_\_\_\_

**PARENTAL PERMISSION TO TRAVEL AND RELEASE OF LIABILITY**

**Both parents must sign this section. (If a parent is deceased or divorced, please indicate so in writing.)**

As a parent or guardian, I give my permission for my child (name) \_\_\_\_\_ to travel to (country) \_\_\_\_\_ to participate in MTW's Volunteer Ministries Program on the following dates: \_\_\_\_\_. I am aware of the inherent risks and dangers to my child in traveling to and visiting other countries and the potential risks to my child and his/her property as a result of participation in the \_\_\_\_\_ project (including but not limited to illness, injury, acts of terrorism, death, robbery, kidnapping, or other loss or destruction of life or property). I fully assume these risks, understanding that MTW cannot be responsible for any personal loss or disaster that my child may experience in connection with his/her volunteer ministry service to MTW. I hereby agree to waive and release any and all claims and causes of action for damages or other relief that I may have against MTW, the Presbyterian Church in America, my sending organization, any of their affiliated or member entities, and their respective officers, directors, employees, agents, attorneys, or representatives, based on my child's volunteer services for MTW. I acknowledge personal responsibility for my child's actions outside the direction of ministry personnel, or the scope of this ministry project or program. I understand that this release of liability is effective only as it applies to, and as interpreted by the laws of the countries involved.

**Signature of father:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print name:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Signature of mother:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print name:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Other legal guardian:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print name:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**NOTARIZATION** (required if traveling outside the United States)

State of \_\_\_\_\_ County of \_\_\_\_\_ Acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public: \_\_\_\_\_ Date commission expires: \_\_\_\_\_ (notary seal required)

## MINOR MTW RELEASE FORM

### MEDICAL HISTORY

**1. Please check any conditions for which you have been treated or seen a physician.**

Heart Trouble	Kidney Stone or Infection	Digestive / Intestinal Disorder
Heart Murmur	Bladder Stone or Infection	Colitis
Abnormal Pulse	Gall Bladder Disease	Ulcer
Rheumatic Fever	Internal Bleeding	Gout
Chest Pain	Prostate Trouble	Deformity / Amputation
Stroke	Sugar, Albumin, Blood or Pus in Urine	Skin Disorder
High Blood Pressure	Psychiatric Problem	Hernia
Hardening of the Arteries	Emotional/Nervous Problem	Disease of Eyes
Diabetes	Epilepsy / Convulsion	Disease of Ears
Circulatory Disorder	Other Nervous System Disorder	Disease of the Nose / Throat
Blood Disorder/Disease	Cancer / Tumor	Bronchitis
Hepatitis	Dizziness / Loss of Consciousness	Tuberculosis
Anemia	Frequent Headaches	Other Lung Disorder
Thyroid/other Gland Problem	Arthritis	<b>Asthma*</b>
Cirrhosis / Liver Trouble	Sciatica	<b>Allergy**</b>
<b>Pregnant</b> (currently): <i>Pregnant women are not permitted to participate on projects rated as Intermediate, substantial or high risk. Check with your Project Administrator if you are not sure of your project rating.</i>		

\*Some project locations are **high altitude**. Check with your project administrator if you are not sure of your project altitude.

**2. Are you currently being treated for any of the above conditions?**     Yes     No

If yes, please list the condition and the date of most recent treatment/doctor's visit:

**3. Are you currently taking any prescription medications?**     Yes     No

If yes, please list the names of the medications:

**4. Please list all allergies, including food and medications:**

*Note: If you have an allergy that requires an EpiPen or other treatment, please bring the appropriate medication with you.*

### IMMUNIZATIONS

- 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, but he/she will have by the beginning of the project.
- I have checked with my doctor, the CDC, or the health department and am aware of the immunizations recommended and required for the area to which my child will be traveling.     Yes     No

### MEDICAL CONSENT

**Both parents must sign this section. If a parent is deceased or divorced, please indicate so in writing.**

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

Signature of father: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of mother: \_\_\_\_\_ Date: \_\_\_\_\_

Other legal guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of team leader:** \_\_\_\_\_ **Date:** \_\_\_\_\_