

Last Name: _____

First Name: _____

Travel Release Form

This form is REQUIRED for participation on your mission trip!

The Travel Release Form is an **extremely vital** item for you as a participant. Trail Blazer Missions and your Trail Guide use Travel Release Forms in case of medical treatment/concerns and for accountability to the discipline agreement. Note that Parent/Guardian signatures are required **only if** the participant is under 18. Follow these three (3) easy steps to completing this form: Health Insurance, Medical Information and Notarization.

Step 1: Health Insurance

Important Information:

- A copy of the insurance card must be provided.
- ****Without medical insurance covering international travel, you/your child will not be able to participate on a mission trip with Trail Blazer Missions.*** If you do not have health insurance, comprehensive, temporary health insurance plans are available. Contact your local insurance agent, or search the web.

Consent for Medical Treatment

Participants Name: _____

Birth Date: ___ / ___ / ___

_____ (participant), wishes to be a part of a Trail Blazer Missions, missionary group, which will be traveling to and staying in _____ (country/project) and certain circumstances may occur resulting in my/my child's need for medical/dental care and treatment, and further resulting in my inability to personally give consent for such care and treatment; In consideration of **permission from Trail Blazer Missions** for myself/my child to participate in said **missionary group**, I (parent/guardian if participant is under 18 years of age), _____, being of legal age, authorize Trail Blazer Missions, or any **designated agent** of Trail Blazer Missions, or medical facility to act on my/my child's behalf should I be unable to do so and consent to **all** medical/dental care and treatment, including but not limited to diagnostic tests, x-ray examination, anesthesia, surgery or other procedures which **Trail Blazer Missions deems necessary** for my/my child's medical well-being for the duration of the mission. This consent is given in advance of any specific diagnostic tests, treatment, surgery or medications, and is given to provide authorization and specific consent for medical/dental treatment and care in my/my child's behalf. Any consent by Trail Blazer Missions shall have the same force and effect as if I had personally given the consent.

I certify that I have personal health insurance, **including foreign countries, with no territorial limitation, for the providing of medical services to me/my child** which will provide coverage for me/my child during the duration of said mission. I understand that Trail Blazer Missions provides no health insurance plan.

I understand that all copies required by my insurance company will be due to my health care provider at the time of treatment or office visit. If a copy is not presented at the time of visit, health care facilities reserve the right to refuse treatment for non-urgent visits.

Policy Holder's Name

Policy #

Insurance Company

() _____
Insurance Company Phone Number

Mother/Guardian's Information:

Name: _____

Address: _____

Work Phone: () _____

Home Phone: () _____

City: _____ State: ___ Zip: _____

Alternate Phone: () _____

Father/Guardian's Information:

Name: _____

Address: _____

Work Phone: () _____

Home Phone: () _____

City: _____ State: ___ Zip: _____

Alternate Phone: () _____

In case of an emergency where parents cannot be reached, contact:

Name: _____

Address: _____

Work Phone: () _____

Relationship to Applicant: _____

Home Phone: () _____

City: _____ State: ___ Zip: _____

Alternate Phone: () _____

Participant Initials _____

Step 2: Medical Information

Important Information:

Last Name: _____

First Name: _____

- We cannot use information and/or documents from previous mission trips because this form is used specifically for each mission trip and is not reusable. We use this information for the participant's health and safety.
- You must answer every question on the "Medical Checklist." Any misrepresentation will void the participant's acceptance.

What you need to complete this section:

- You will need the participant's immunization record to complete this step. We **do not** have access to records of the participant's shot dates from previous trips. The participant's tetanus shot (received every ten years) must be up-to-date before participating in the Trail Blazer Missions trip.

Medical Checklist *please indicate if the participant has:*

	Yes	No		Yes	No
Asthma or chronic wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Any other respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cysts or Tumors of any kind	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Skin disorder other than acne	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or any other blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Serious bodily injury	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid ailment	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory trouble	<input type="checkbox"/>	<input type="checkbox"/>	Severe allergic reactions	<input type="checkbox"/>	<input type="checkbox"/>
Hearing or Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>	AIDS Virus or HIV	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Metabolism	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder stones or colic	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism, Arthritis, Painful swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Severe knee problems	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal or bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	Persistent, recurring indigestion, stomach or duodenal ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Breast or menstrual disorder	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Any other disease or disability	<input type="checkbox"/>	<input type="checkbox"/>
Any cardiac problems	<input type="checkbox"/>	<input type="checkbox"/>	not listed above		
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>			

If you checked 'yes' to any question on this Medical Checklist, take this form to your physician so that they may complete the following section.

- If you checked 'no' to all the questions on the Medical Checklist, proceed to **Childhood Immunizations**.

Doctor's Release Section

(To be completed by your physician)

In the past, Trail Blazer Missions has had participants who have experienced difficulty engaging in daily activities on the mission field. The participant may be involved in challenging drama training (choreography) and extended periods of walking and hiking as part of the daily itinerary. Dietary and climate changes also add to the physical intensity of our trips as well as the high probability of, at some point, experiencing lack of sleep. Please be considerate of these factors.

Physician's Printed Name: _____ Phone Number: (____) _____ - _____
Address: _____ City: _____ State: ____ Zip: _____

Blood Pressure: _____ (Optional) **Age:** _____ **Birth Date:** _____ / _____ / _____

I have reviewed this patient's **Medical History**, and I have performed a physical exam. *(Please check the appropriate choice)*

- I find him/her to be in adequate condition for international travel, participation in high-intensity activities and choreography in a third world country.
- I have prescribed a medical plan of action for him/her to meet prior to the mission trip in order to participate in the daily itinerary during the mission trip.
- I do not recommend this person to participate at this time.

Physician's Signature: _____

Date: _____ / _____ / _____

Participant Initials _____

Last Name: _____

First Name: _____

(Step 2, continued)

Childhood Immunizations (to be completed by parent/guardian)

Type	Yes	No	Year Administered
Mumps/Measles/Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diphtheria/Pertussis/Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____			_____

Type	Yes	No	Year Administered
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____			_____

I, _____, **agree** that it will be my sole responsibility to obtain information on travel immunizations required/recommended and travel precautions for the area. I realize that **immunizations must be completed 4-6 weeks prior to travel.**

Please complete the following questions:

- Are you currently taking any prescribed medication? Yes No
If yes, please specify the medication and the dosage: _____
- Are you currently using any non-prescription drugs on a regular basis? Yes No
If yes, please specify: _____ Will you take these on your trip? _____
- Are you allergic to any medications/foods? Yes No
If yes, please specify which medications/foods: _____
- Have you ever received treatment/counseling for alcohol or chemical abuse? Yes No
If yes, please specify when and where: _____
- Are you presently under a physician's care for any illness? Yes No
If yes, please explain: _____
- What was the date of your most recent physical exam and who was the Physician? _____
- Are you a vegetarian? Yes No
If yes, how long? _____
What are your limitations based on health requirements, not preferences? _____

Note to vegetarians: You may need to eat meat as part of cultural sensitivity!

Please list all surgical operations or hospitalizations the participant has undergone. (For more than 2, please attach a sheet of paper.)

1. Operation, illness: _____
Reason: _____ Date: ____ / ____ / ____
Name and address of hospital: _____
Name of Physician: _____
Remaining Effects: _____
2. Operation, illness: _____
Reason: _____ Date: ____ / ____ / ____
Name and address of hospital: _____
Name of Physician: _____
Remaining Effects: _____

Please provide any details pertaining to your health not covered in this Travel Release Form. (Attach an additional sheet of paper if necessary). _____

*** Remember to include a copy of your insurance card!**

Participant Initials _____

Last Name: _____

First Name: _____

Step 3: Notarization

Important Information

- Parent/Guardian signatures are required **if** the participant is under age 18.
- Parents/Guardians and participants must sign this form **in the presence of a Notary Public**.
- All those with legal custody of the participant **MUST** sign this form in the presence of a Notary. If the participant is in the legal custody of both parents, then **BOTH** parents' signatures are *required*.

What you need to complete this section:

- If you are **NOT** in the legal custody of both parents, your parent/guardian who has legal custody of you **MUST** sign this form **and** a copy of a legal document (EVIDENCING THE *SOLE CUSTODY ARRANGEMENT*) or a **COPY** of the death certificate for a deceased parent **MUST BE PROVIDED**. If you only have one parent, we must have a **COPY OF YOUR BIRTH CERTIFICATE SHOWING ONLY ONE PARENT**. We apologize for the inconvenience, but this is for your/your child's safety as well as assurance of entrance into the country.
- This form **must be stamped and signed by a Notary Public**. A Notary may be found at a school, bank, real estate office, etc. Without the signatures signed in the presence of a Notary Public, this Travel Release Form is considered incomplete, and will not complete the processing of the participant's mission trip.

Medical and Travel Release: *(If you are under age 18, a parent/guardian must complete the following.)*

On behalf of myself/my child, I further authorize Trail Blazer Missions to:

- Release any and all other medical information or records to any party deemed necessary by Trail Blazer Missions, its agents, servants, employees;
- Assign for the providing of medical treatment to my child or to members of the missionary group;
- To insure proper placement of my child in such group.

I hereby release Trail Blazer Missions, its agents, servants, employees and assigns for any and all damages, liability or costs resulting from the authorizing of medical treatment on my/my child's behalf under the terms of this consent. I further hold Trail Blazer Missions harmless from any and all costs, damages or expenses incurred by Trail Blazer Missions as a result of any claim or action filed by any party alleging damages incurred as a result of any medical treatment provided or authorization for treatment provided. I understand that this release and indemnification releases treatment for the conduct of Trail Blazer Missions and its agents, servants, employees or assigns even if such conduct is negligent.

I am aware that serious illness or injury may occur on a mission trip and that such illness and injury may result in myself/my child incurring costs, expenses, and damages for which I am solely responsible including, but not limited to, return of myself/my child by air ambulance or other extraordinary means.

I hereby release and hold harmless Trail Blazer Missions, its officers, employees, and representative/volunteers from all liability for personal injury, including death, as well as all property damage or loss arising out of my/my child's participation in this trip.

I also give Trail Blazer Missions the right to use my/my child's picture, voice and/or testimony in any form of promotional or advertising materials.

Accountability Agreement:

The rules and regulations of Trail Blazer Missions are expressly designed to ensure the safety and well-being of each team member and to maintain the high degree of Christian integrity required to minister effectively in a cross-cultural setting. The enforcement of all aspects of these rules and regulations are the responsibility of the Trail Blazer Missions staff, which includes Project/Adventure Directors, Team Leaders and Trail Guides. Enforcement shall occur in a manner, which **Trail Blazer Mission staff** feels is in accordance with Christian principles and the stated purpose of the project. We expect full cooperation from members and parents in disciplinary decisions made. The discipline committee reserves the right to send home any team member that shows disregard for the stated rules and regulations. The team member and/or their family are responsible for **any** cost involved in sending the team member home. These costs may include, but are not limited to, airfare, hotel and food for the team member **and** chaperone. I have read the rules, regulations and the disciplinary measures and agree to abide by them.

Last Name: _____

First Name: _____

Behavioral Agreement

By participating in a Trail Blazer Missions mission trip, I understand I am expected to follow the stated rules as well as carry myself according to Christian principles. I understand the Trail Blazer Oath is the standard of conduct for all Trail Blazer members and will follow it to the best of my ability. The characteristics of the Trail Blazer Oath include:

- Honor - I will be honorable through thoughts, actions and speech daily.
- Faith - I commit to listen to and obey God's Word, knowing that when I do so, His power will be made manifest in my life and in the lives of others.
- Relationships - I commit to love and esteem others higher than myself, understanding that my leaders, team members and the people of the world are God's creation and are to be treated with love and respect.

My enclosed signature signifies my approval of all limitations listed above as well as my agreement with the *Accountability and Behavioral Agreement/Code of Conduct*. I have read and understand the above information. My signature represents that all information on these forms is true and correct to the best of my knowledge.

Father's signature (if applicant under 18)

Mother's signature (if applicant under 18)

____ / ____ / ____
Date

Guardian's signature (if applicant under 18)

Participant's signature

____ / ____ / ____
Date

THIS SECTION MUST HAVE A RAISED SEAL STAMP FROM THE NOTARY!

FOR NOTARY

State of _____

County of _____

Before me, the undersigned, a Notary Public in and for said county and state on _____, 20____, personally appeared the identical person who executed the within and foregoing instrument, and acknowledged to me that he/she executed the same as his/her free and voluntary act and deed, for the uses and purposes therein set forth. Given under my hand and seal of office the day and year above written.

Notary Stamp

Notary Signature

My commission expires ____ / ____ / ____

Notary Raised Seal

**Note to notary: If you do not have a notary stamp we need other proof of notary such as a copy of notary certificate.*