



CrossRoads Missions

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FORM C

For Ages 17
and under

Medical, Dental and Photography Permission Form for Youth. Please print a copy of this form to have it notarized. Once notarized give this form to your Trip Leader.

Group/Trip Name: Date:

Ministry Field: Appalachia Inner City Mexico New Orleans

Name: Nickname:

Address:

City: State: Zip:

Date of Birth: SSN: Female Male

Home Phone: Cell Phone: Email:

Father/Guardian Name:

Address: SSN:

Home Phone: Cell Phone: Email:

Mother/Guardian Name:

Address: SSN:

Home Phone: Cell Phone: Email:

Please provide employment information for your parent or guardian unless your insurance coverage is provided by your own employer.

Employer Name/Address:

Employer Contact Name: Telephone:

Health Provider / Insurance Information - Medical/Health Insurance is required!

Insurance Carrier: Policy #:

Name of Policy Holder:

IMPORTANT

- Include a copy of your current insurance card with this form.
- If you are traveling to our Mexico field, please include a copy of your *passport*.

Please list all prescribed and over-the-counter medication(s) used.

Please list any allergies, including **medicine, food and insect allergies**.

Date of your most recent Tetanus immunization:

In event of an emergency, please notify:

Name:

Address:

Home Phone:

Cell Phone:

Please check any of the conditions or symptoms listed below that you have, are being treated for or have had in the past five years.

- | | | |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Knee/Ankle Problems | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neck/Back Problems | <input type="checkbox"/> Medical Equipment |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Leg/Foot Problems | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Headaches | <input type="checkbox"/> Intestinal Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Active Bedwetting |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neurological Concerns | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heat Intolerance / Stroke | <input type="checkbox"/> Unexplained Sweating |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bladder Problem | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Hearing Impaired | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Vision Impaired | |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Wheelchair Bound | |
| <input type="checkbox"/> Frostbite/Cold Tolerance | <input type="checkbox"/> Motion Sickness | |
| <input type="checkbox"/> Circulation Concerns | <input type="checkbox"/> Sleep Walking | |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Currently Pregnant | |
| <input type="checkbox"/> Arm/Shoulder Problems | <input type="checkbox"/> Special Diet | |

For any checked item above, please indicate that item below and provide the following information: frequency, duration, treatment, date of last occurrence or any other information for which we should be aware.

By signing this form, I, as parent/guardian, do hereby grant and convey to CrossRoads Missions, its partners and affiliates, all right, title and interest in any and all photographic images, video and audio made by CrossRoads Missions during for participation in activities identified by or related to this form. This includes, but is not limited to royalties, proceeds or other benefits derived from such materials.

Furthermore, I, as parent/guardian, for myself and the named participant on this form, and on behalf of my estate, heirs, executors and administrators do hereby fully release and discharge CrossRoads Missions, including their partners and affiliates, from any and all liabilities, claims, obligations, damages and causes of action whatsoever arising or growing out of my travel and/or participation in the programs of CrossRoads Missions. I also understand that I am responsible for all medical bills related to such activity. Should it be necessary for me to return home due to medical reasons or disciplinary action, I will assume total responsibility for all transportation costs to and from the event. I understand, that as a CrossRoads Missions participant, that I am serving at my own risk and that CrossRoads Missions is not liable in the event of sickness, injury, accident, theft, terrorist acts or death.

I, as parent/guardian, hereby consent and authorize CrossRoads Missions, its partners, affiliates, agents and designees, to authorize any medical treatment deemed necessary while participating in any activity applicable to this form should the named participant be mentally and/or physically incapable of making such a decision. My signature likewise indicates that the information that I have provided on this application is true and accurate and that I have read this entire document, understand it completely and agree to the conditions and terms stated herein.

This form should only be signed in the presence of a Notary who is licensed in your state of residence.

Printed Parent/Guardian Name:

Parent/Guardian Signature:

Date:

Notary

Subscribed and sworn to before me this _____ day of _____, 20 ____

Notary: _____

My commission expires ___ / ___ / ____

Seal: