

**MEDICAL RELEASE FOR VOLUNTEER SERVICE**

**This form needs to be completed by volunteer. Please send it back to STM ASAP. It cannot be accepted within 30 days of departure.**

It is very important that each volunteer be physically able to serve in their respective country of service, and to fully disclose any medical conditions so that the hosting partner/missionary can be prepared in the event of an emergency. This information will be kept confidential, held by International Ministries, and given only to the hosting facility.

Name: Last First Middle

Address:

Phone #: Date of Birth: (Month / Day / Year)

Location of Volunteer Service:

Assignment (description of service):

# Any known disease or disability? YES NO

If yes, give details and explain how this might or might not affect your international assignment.

# Any regular medication needed? YES NO

If yes, complete the following...

* 1. List medication(s), form (liquid, tablet, injection, etc.) and if refrigeration is needed.

*Please continue list on another sheet if necessary*

* 1. If you cannot take a large enough supply to last the duration of your international service, what provisions have you to get more?

# Please list any dietary restrictions you have:

1. **Please list any allergies that you have – (i.e, food, medicine, animal, environmental).**

Medical Release/Emergency Contact/Insurance Form - 2 -

# Physician's name (Print)

**Address Office Phone**

**INSURANCE INFORMATI~~ON:~~**

Insurance Company:  ~~Policy or Group #:~~

**EMERGENCY CONTACT*:*** In case of an emergency, who should be contacted on your behalf?

Name Relationship to you Phone

Name Relationship to you Phone

In the event of a medical emergency resulting in my (and my spouse, if accompanying me on the mission) being incapacitated and not competent to make responsible decisions concerning my medical treatment, I hereby authorize those responsible for overseeing the mission in which I am serving to take me to the nearest licensed physician, medical center or hospital, and to secure necessary treatment (medications, injections, anesthesia or surgery) to protect my well being. I will be responsible for all medical costs not covered by my insurance.

In the event of a medical emergency involving my spouse or my or our dependent who is accompanying me on the mission in which I am serving, which occurs while I (and, if applicable, my spouse) is incapacitated and not competent to make responsible decisions concerning the medical treatment of my spouse or any such dependent, I hereby authorize those responsible for overseeing the mission to take my spouse or dependent to the nearest licensed physician, medical center or hospital, and to secure necessary treatment (medications, injections, anesthesia or surgery) to protect the well being of my spouse or dependent. I will be responsible for all medical costs not covered by any applicable insurance.

# Signature Date:

**Print Name:**

**For married travelers or those traveling with non-minor dependents only:** This form should also be signed below by the volunteer’s spouse, as well as any non-minor dependent, that will be accompanying the volunteer on the trip.

# Signature Date:

**Print Name:**

**Signature Date:**

**Print Name:**

American Baptist International Ministries,1003 W., 9th Avenue, King of Prussia, PA 19406

1-610-768-2168 fax 610-768-2115 Rev092214