



# futureVision Ministries

## Adult Medical Information

Name of participant: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
Mission Country: \_\_\_\_\_ Trip Date: \_\_\_\_\_

### In case of emergency contact:

Name: \_\_\_\_\_ Home Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Please complete the following:

- Yes  No  
✂ Are you currently taking any prescribed medication?  
If yes, please specify the medication and the dosage. \_\_\_\_\_
- Yes  No  
✂ Are you currently using any non-prescription drugs on a regular basis;  
such as antihistamines or sleeping aids?  
If yes, please specify. \_\_\_\_\_
- Yes  No  
✂ Have you ever received treatment or counseling for alcohol or chemical abuse?  
If yes, please specify when and where. \_\_\_\_\_
- Yes  No  
✂ Are you presently under a physician's care for any illness?  
If yes, please explain. \_\_\_\_\_

### List all surgical procedures or hospitalizations you have had:

- 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 \_\_\_\_\_
- 3) Please provide any details pertaining to your health not covered by the above questions \_\_\_\_\_

(over)

## All questions must be answered.

*Have you ever been treated by a doctor for any of the following (Please check every item)*

- |   |  |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Asthma or chronic wheezing</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Emphysema or other lung and/or respiratory problems</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chronic persistent cough or shortness of breath</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Any skin disorder or disease other than acne</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Diabetes or hypoglycemia (low blood sugar)</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Cancer</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Impairment of hearing or vision. Meniere's Disease, cataracts or glaucoma</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Albumin, blood or pus in the urine; painful or frequent urination; or kidney problems</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Rheumatism, gout, arthritis or other forms of swollen painful joints</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chronic back pain, back injury, or surgery; sciatica, scoliosis or other bone or joint disorder</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>High blood pressure, heart murmurs or other cardiac problems</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorder or venereal disease</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Severe knee injury or problems (This is very IMPORTANT due to the nature of the drama.)</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Severe allergic reactions to either food, medicines, bee stings or any other insect bite or sting</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Any other diseases, deformity, or disability not listed above.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Tuberculosis</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Gall bladder stones or colic</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Chronic/recurrent ear or eye problems</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Jaundice, cirrhosis or other liver problems</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Serious bodily injury</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Severe migraine headaches</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Persistent, recurring indigestion, stomach or duodenal ulcers</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Any test results indicating exposure to the AIDS virus</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Mental health counseling or psychiatric treatment</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Cyst, tumors or growths of any kind, hernia or rupture</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Fainting spells, dizziness, convulsions, epilepsy or seizure disorder</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Vein or circulatory trouble</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Parkinson's Disease</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Anemia or other blood disorder</i><br><input type="checkbox"/> Yes <input type="checkbox"/> No <i>Goiter, thyroid ailment, high or low metabolism</i> |
|---|--|

### Consent For Medical Treatment; Release and Hold-Harmless For Travel

I, \_\_\_\_\_, hereby affirm and agree that I am aged 18 years or older, that I am legally competent to sign this agreement and release; that I have fully informed myself of this agreement by reading it before signing, and that I have fully informed myself of the details and risks of the Activity prior to signing this release. I, wish to be a member of a **futureVision Ministries** mission team which will be traveling to and staying in \_\_\_\_\_ (country), and WHEREAS, I agree, individually and on the behalf of my heirs, to release and to hold harmless **futureVision Ministries, Inc.**, its agents, officers, directors, and employees (collectively referred to as "the Ministry") from liability for my injury, death, or damage to or loss of my personal property, resulting directly or indirectly from my participation in the Activity. I personally assume all risks and liabilities in connection with my participation in the Activity and agree to indemnify the Ministry from any liability assessed against the Ministry as a direct or indirect result of my participation in the Activity. This release includes all risks and liabilities connected with the Activity, whether foreseen or unforeseen.

In the event that I am injured during the Activity, and I am unable to provide consent to my medical treatment, I authorize the Ministry to consent on my behalf to the performance of any and all medical treatment judged necessary by the Ministry, until I am able to provide consent or until someone legally able to speak on my behalf is made available. I agree, individually and on behalf of my heirs to release, indemnify, and hold the Ministry harmless from any liability which may be assessed against the Ministry as a direct or indirect result of said medical treatment. I am aware that serious illness, requiring the return by air ambulance could cost more than \$10,000.00. I agree to pay or arrange for payment of all costs associated with said medical treatment.

I also give Ministry the right to use my picture, voice and/or testimony in any form of promotional or advertising materials. My signature signifies my approval of all limitations listed above.

**THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY TO BE VALID**

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

State of \_\_\_\_\_ County of \_\_\_\_\_

Before me, the undersigned, a Notary Public in and for said county and state on \_\_\_\_ day of \_\_\_\_\_, 20\_\_, personally appeared the identical persons who executed the within and foregoing instrument, and acknowledged to me that they executed the same as their 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 Signature: \_\_\_\_\_

My commission expires: \_\_\_\_\_ My commission number: \_\_\_\_\_