ADULT MTW RELEASE FORM

Participant: Please complete ALL information requested, give completed 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): _____

Email: _____ Church name: _____

Address: _____ Church city/state: _____

City, state, zip: _____ Team leader: _____

Phone: _____

Emergency contact name and phone (must not be a trip participant): _____

PROJECT INSURANCE COVERAGE AND REQUIREMENTS

1. **What we provide:**

   MTW short-term provides $200,000 travel evacuation coverage for each participant on international projects. This includes emergency evacuation expenses when necessitated by circumstances occurring more than 50 miles from home. This coverage is provided for all participants in the short-term program and is included in the project cost.

2. **What we require:**

   MTW's project insurance acts as a secondary coverage. **Each participant is required to have his/her own primary emergency** medical coverage. For international projects, the primary coverage must cover a participant while overseas. Any participant, who does not have a primary medical insurance policy, must apply for supplementary coverage. Recommendations have been provided to your team leader.

3. **Please indicate the status of your primary medical insurance:**

   - ○ I do have a primary medical insurance policy, and I have confirmed that it will cover me while outside the US on this project. **Insurance Company:** _____
   - ○ I have primary medical insurance, but it will **not** cover me outside the US. I am applying for supplemental coverage.
   - ○ I do not have a primary medical insurance. I am applying for supplementary coverage.

RELEASE OF LIABILITY

I am aware of the inherent risks and dangers in traveling to and ministering in other countries and the potential risks to myself and my 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 I may experience in connection with my 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 church/organization**, any of their affiliated or member entities, and their respective officers, directors, employees, agents, attorneys, or representatives, based on my volunteer services for MTW. I acknowledge personal responsibility for my own 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.

Have you ever been accused or convicted of child sexual abuse? ○ Yes ○ No

Signature of adult participant: _____ **Date:** _____

ADULT MTW RELEASE FORM

MEDICAL HISTORY

As a project participant, you are asked to give the following health information, in order for the project administrators to be aware of any risk your participation may create. Project administrators are free to require a doctor's release statement if a serious health problem exists. Failure to provide known information will release both the team leader, MTW, and project administrators from responsibility arising due to complications brought on by the activities of this project.

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		**Asthma***
	Cirrhosis / Liver Trouble		Sciatica		**Allergy****
	Pregnant (currently): *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.*				

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 AND MEDICAL CONSENT

1. I have had all routine immunizations *(dT-diphtheria, tetanus, MMR-measles, mumps, rubella, and polio).*
   ○ Yes ○ No

2. I have had a tetanus booster within the past 10 years.
   ○ Yes ○ No, but I will have by the beginning of the project.

3. 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 I will be traveling. ○ Yes ○ No

4. **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.

Signature of adult participant: _____ **Date:** _____

Signature of team leader: _____ **Date:** _____