MINOR MTW RELEASE FORM (0-17 years)

Participant: Please complete ALL information requested, give completed and notarized 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: Chiba & Shizuoka, Japan

Date of birth *(mm/dd/yyyy)*: _____ Project dates: Nov. 8-17, 2019

Gender (male/female): _____ Church name: _____

Address: _____ Church city/state: _____

City, state, zip: _____ Team leader: _____

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

INSURANCE REQUIREMENTS

Each MTW participant is required to have his/her own primary medical insurance. For international projects, the primary insurance must cover the participant while overseas. Any participant who does not have a primary medical insurance policy must apply for short-term coverage.

Please indicate the status of your medical insurance coverage:

- ○ I do have primary medical insurance coverage and I have confirmed that it will cover my child while outside the US on this project. **Insurance Company:** _____
- ○ I have primary medical insurance coverage, but it will **not** cover my child outside the US. I have obtained short-term coverage with: _____
- ○ I do **not** have primary medical insurance coverage. I have applied for short-term coverage for my child with: _____ _____

PARENTAL PERMISSION TO TRAVEL AND RELEASE OF LIABILITY

Both parents must sign this section. ***(If a parent is deceased or divorced, please indicate so in writing.)***

As a parent or guardian, I give my permission for my child (name) _____ to travel to (country) Japan to participate in MTW's Volunteer Ministries Program on the following dates: Nov. 8-17, 2019. I am aware of the inherent risks and dangers to my child in traveling to and visiting other countries and the potential risks to my child and his/her property as a result of participation in the Japan CPI 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 my child may experience in connection with his/her 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 organization, any of their affiliated or member entities, and their respective officers, directors, employees, agents, attorneys, or representatives, based on my child's volunteer services for MTW. I acknowledge personal responsibility for my child's 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.

Signature of father: _____ **Date:** _____

Print name: _____ **Email:** _____ **Phone:** _____

Signature of mother: _____ **Date:** _____

Print name: _____ **Email:** _____ **Phone:** _____

Other legal guardian: _____ **Relationship:** _____ **Date:** _____

Print name: _____ **Email:** _____ **Phone:** _____

NOTARIZATION (required if traveling outside the United States)

State of _____ County of _____ Acknowledged before me this _____ day of_____, 20_____.

Notary Public: _____ Date commission expires: _____ (notary seal required)

MINOR MTW RELEASE FORM

MEDICAL HISTORY

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:** **Also list any conditions with special needs**
   Note: If you have an allergy that requires an EpiPen or other treatment, please bring the appropriate medication with you.

IMMUNIZATIONS

1. My child has had all routine immunizations *(dT-diphtheria, tetanus, MMR-measles, mumps, rubella, and polio).*
   ○ Yes ○ No
2. My child has had a tetanus booster within the past 10 years.
   ○ Yes ○ No, but he/she 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 my child will be traveling. ◉ Yes ○ No

Note from Beth Philbrick: Per the CDC, no immunizations are required for travel to Japan.

MEDICAL CONSENT

Both parents must sign this section. If a parent is deceased or divorced, please indicate so in writing.

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 for my child *(name)* _____.

Signature of father: _____ **Date:** _____

Signature of mother: _____ **Date:** _____

Other legal guardian: _____ **Relationship:** _____ **Date:** _____

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