

## 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 (mo/day/yr): _____	Project Dates: _____
Gender (male/female): _____	Church: _____
Address: _____	Church City/State: _____
City, State, ZIP: _____	Team Leader: _____
Home Phone: _____	
Alternate Emergency Contact Name and Phone: _____	

### PROJECT INSURANCE COVERAGE and REQUIREMENTS

#### 1. WHAT WE PROVIDE

MTW Short-term provides \$75,000 Travel Medical Coverage for each participant. This includes emergency evacuation expenses when necessitated by circumstances occurring more than 150 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** medical coverage. For international projects, the primary coverage must cover them while overseas. Any participant, who does not have a primary medical insurance policy, must apply for supplementary coverage. Additional information and recommendations are attached to this form.

#### Please indicate the status of your primary medical insurance:

##### US projects:

- "I do have a primary medical insurance policy." **Insurance Company:** \_\_\_\_\_
- "I do not have a primary medical insurance, but I am applying for supplementary coverage."

##### International projects:

- "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 (US and international projects)

"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:** \_\_\_\_\_

## MTW RELEASE FORM - ADULT PARTICIPANTS

**MEDICAL HISTORY**

As a project participant, you are asked to give the following health information, in order for the project leadership to be aware of any risk your participation may create. Project leaders 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, Mission to the World, and project leaders from responsibility arising due to complications brought on by the activities of this project.

A. Please check any conditions for which you have been treated or seen a physician.

<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Kidney Stone or Infection	<input type="checkbox"/>	Digestive / Intestinal Disorder
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Bladder Stone or Infection	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	Abnormal Pulse	<input type="checkbox"/>	Gall Bladder Disease	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Internal Bleeding	<input type="checkbox"/>	Gout
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Prostate Trouble	<input type="checkbox"/>	Deformity / Amputation
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Sugar, Albumin, Blood or Pus in Urine	<input type="checkbox"/>	Skin Disorder
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Psychiatric Problem	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Hardening of the Arteries	<input type="checkbox"/>	Emotional/Nervous Problem	<input type="checkbox"/>	Disease of Eyes
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Epilepsy / Convulsion	<input type="checkbox"/>	Disease of Ears
<input type="checkbox"/>	Circulatory Disorder	<input type="checkbox"/>	Other Nervous System Disorder	<input type="checkbox"/>	Disease of the Nose / Throat
<input type="checkbox"/>	Blood Disorder/Disease	<input type="checkbox"/>	Cancer / Tumor	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Dizziness / Loss of Consciousness	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Other Lung Disorder
<input type="checkbox"/>	Thyroid/other Gland Problem	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<b>Asthma*</b>
<input type="checkbox"/>	Cirrhosis / Liver Trouble	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<b>Allergy - Recurring**</b>
<b>Pregnant</b> (currently): <i>(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.)</i>					

\*Some project locations are **high altitude**. Check with your project administrator if you are not sure of your project altitude.)

\*\* If you are allergic to **bee stings**, please bring a current bee sting kit and/or prescription medication to the project.

B. Please explain any conditions listed above that you have been **diagnosed with or treated for in the past five years**. (Include date of last treatment or office visit for each item checked).

C. What **medication**, if any, will the participant be taking during the project (and for what purpose)?

**D. IMMUNIZATIONS AND MEDICAL CONSENT**

- "I have had all routine immunizations, (*dT-diphtheria, tetanus, MMR-measles, mumps, rubella, and polio*)."  
 Yes     No
- "I have had a tetanus booster within the past 10 years."  
 Yes     No, but I will have by the beginning of the project.
- "I have checked with my doctor, the CDC or a travel clinic and am aware of the immunizations recommended and required for the area to which I will be traveling."     Yes     No
- "**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:** \_\_\_\_\_

**Form Reviewed by (Team Leader signature):** \_\_\_\_\_

**Date:** \_\_\_\_\_