



# Medical Consent Form

Whereas, (my child/I) \_\_\_\_\_, wishes to be a member of \_\_\_\_\_ (sponsoring church/group) missionary team which will be traveling to and staying in \_\_\_\_\_ (country), and whereas, certain circumstances and situations may occur resulting in (my child's/myself) need for medical/dental care and treatment, and further resulting in my inability to personally give consent for such care and treatment:

Therefore,

1. In consideration of permission for my child to participate in said mission, I \_\_\_\_\_, being of legal age, authorize ICFG or any agent of ICFG, to act in my child's behalf should I be unable to do so and to consent to reasonable medical/dental care and treatment, including but not limited to diagnostic testing, x-ray examination, anesthesia, surgery, or other procedures which may be deemed necessary for my child's medical well-being for the duration of the mission trip.
2. This consent is given in advance of any specific diagnosis, treatment, surgery, or hospital care required, but is given to provide authorization and specific consent for medical/dental treatment and care on my child's behalf.
3. Any consent by ICFG shall have the same force and effect as if I had personally given the consent.
4. I hereby release and hold harmless ICFG, its officers, employees, and representatives/volunteers from all liability for personal injury, including death, as well as all property damage or loss arising out of my child's participation in this trip.
5. My child's passport # is: \_\_\_\_\_, Issuing Country \_\_\_\_\_

If the child is under the custody of both parents, both parents' signatures are needed. If the child is not, we need the signature of the parent who has legal custody of the child. (Some foreign countries require this.)

\_\_\_\_\_  
Father's Signature (if applicant is under 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother's Signature (if applicant is under 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian's Signature (if applicant is under 18 years of age)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

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

.....  
.....  
Before me, the undersigned, a Notary Public in and for said county and state on \_\_\_\_\_,  
20\_\_\_\_, personally appeared the identical person who executed the within and foregoing instrument, and  
acknowledged to me that he/she executed the same as his/her 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.

My commission expires \_\_\_\_/\_\_\_\_/\_\_\_\_.

Notary Public (Stamp)

Please make sure that you have received a list of required and suggested immunizations for the  
country you plan on entering. Your shot records must be up to date. Some countries ask to see  
your shot record before entry is granted.

Please answer the following question to the best of your knowledge.

Have you ever been treated by a doctor for any of the following (every item must be checked)?

Yes No

- \_\_\_\_ Asthma or chronic wheezing
- \_\_\_\_ Emphysema or other lung and/or respiratory problems
- \_\_\_\_ Chronic, persistent cough or shortness of breath,
- \_\_\_\_ Tuberculosis
- \_\_\_\_ Any skin disorder or disease other than acne
- \_\_\_\_ Chronic/recurrent ear or eye problems
- \_\_\_\_ Impairment of hearing or vision
- \_\_\_\_ Persistent, recurring indigestion, stomach or ulcers
- \_\_\_\_ Gall bladder stones or colic
- \_\_\_\_ Jaundice, cirrhosis or other liver problems
- \_\_\_\_ Intestinal or bowel problems, colitis, hemorrhoids, other rectal problems or bleeding
- \_\_\_\_ Any test results indicating exposure to the AIDS virus
- \_\_\_\_ Albumin, blood or pus in the urine; painful or frequent urination; or kidney problems
- \_\_\_\_ Diabetes or hypoglycemia (low blood sugar) \*DIABETICS, at times there will be limited  
access to supplies for specialized diets

- ☐ ☐ Serious bodily injury
- ☐ ☐ Mental health counseling or psychiatric treatment
- ☐ ☐ Rheumatism, gout, arthritis or other forms of swollen painful joints
- ☐ ☐ Chronic back pain, back injury or surgery; sciatica, scoliosis or other bone or joint disorder
- ☐ ☐ Cysts, tumors or growths of any kind, hernia or rupture, cancer
- ☐ ☐ Fainting spells, dizziness, convulsions, epilepsy or seizure disorder
- ☐ ☐ High blood pressure, heart murmurs or other cardiac problems
- ☐ ☐ Vein or circulatory trouble
- ☐ ☐ Severe migraine headaches
- ☐ ☐ Thyroid ailment, high or low metabolism
- ☐ ☐ Anemia or other blood disorder
- ☐ ☐ Abnormality or reproductive systems, prostate problems, breast disorder, menstrual disorders, or venereal disease
- ☐ ☐ Parkinson's disease
- ☐ ☐ Severe knee injury or problems
- ☐ ☐ Allergies to medications
- ☐ ☐ Any other diseases, deformity, or disability not listed above

Are you currently taking any prescribed medication? Yes ☐ No ☐ If yes, please specify the medication and the dosage.

---



---

Are you currently using any non-prescription drugs on a regular basis; such as antihistamines, sleeping aids? Yes ☐ No ☐ If yes, please specify.

---



---

Are you presently under a physician's care for any illness? Yes ☐ No ☐ If yes, please explain.

---



---

#### Family Medical History

Do your grandparents, parents, or siblings have:

Yes ☐ No ☐ Diabetes Yes ☐ No ☐ Hypertension Yes ☐ No ☐ Heart Disease

Yes ☐ No ☐ Depression Yes ☐ No ☐ Mental Illness

---

Applicant's Signature

---

Date

---

Parent's Signature (If under 18 years of age)

---

Date