

# MWOA INTERNATIONAL SERVICE RELEASE



1. Application for trip to: \_\_\_\_\_ Project Dates: \_\_\_\_\_
2. Skills and Abilities: \_\_\_\_\_
3. Name: *(as it appears on passport)* \_\_\_\_\_ Gender: ~M \_ F
4. Address: \_\_\_\_\_  
Street, Apt. Etc. (both P.O. Box and physical address)
5. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
6. E-mail: \_\_\_\_\_ Home Phone: \_\_\_\_\_
7. Work Ph: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell Ph: \_\_\_\_\_
8. Your Birth Date: \_\_\_\_\_ Citizenship: \_\_\_\_\_ (City, State and County of Birth)
9. Place of Employment: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
10. Have you ever traveled outside the U.S. and Canada? If so, where? \_\_\_\_\_
11. Do you have a passport? \_Yes \_No Passport Number: \_\_\_\_\_
12. What country: \_\_\_\_\_ Where was it issued? \_\_\_\_\_ Expiration date: \_\_\_\_\_
13. Marital Status: \_ Single \_ Married Spouse Name: \_\_\_\_\_
14. IN CASE OF EMERGENCY, PLEASE NOTIFY:  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Ph: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I, \_\_\_\_\_ (*your name*), as a volunteer understand and am aware of the risk associated therewith and voluntarily assume such risks as a volunteer by participating in and aiding the Men and Women of Action in rendering service to this project. If accepted as a member of this MWOA team, I agree to: Release and discharge the organizations and individuals which helped make these arrangements, including the MWOA, Int'l Church of God, their agents, employees, officers and volunteers from all claims, demands, actions, judgments or executions that I have ever had, or now have, or may have, or which my heirs, executors, administrators, or assigns may have or claim to have, against these organizations, their agents, employees, officers and volunteers, and their successors or assigns, for all personal injuries, known or unknown and injuries to property, real or personal, caused by, or arising out of this journey. I intend to be legally bound by this statement.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# MEDICAL HISTORY FORM

Men and Women of Action - 4235 T L Rogers St NE - Cleveland, TN 37312  
Phone: (423) 478-7955 - Fax: (423) 478-7408- E-mail: tbennett@cogmwoa.org

DATE: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

Phone # \_\_\_\_\_

I Have Medical Insurance:  YES  NO

If so, Name of Insurance Company: \_\_\_\_\_

**Please provide the following information:**

Do you have, or have you ever had any of the following medical conditions:

**Allergies**  Yes  No If so, allergic to what? \_\_\_\_\_

Are you presently receiving prescribed medication for allergies?  Yes  No If so, specify \_\_\_\_\_

**Asthma**  Yes  No Are you presently receiving a prescribed medication for asthma?  Yes  No If so, specify \_\_\_\_\_

**Diabetes**  Yes  No Are you presently taking insulin or other medication?  Yes  No If so, specify \_\_\_\_\_

**Digestive Disorders** (stomach, colon, etc.)  Yes  No What type? \_\_\_\_\_

Are you presently receiving prescribed medication for this disorder?  Yes  No If so, specify \_\_\_\_\_

**Epilepsy**  Yes  No Are you presently receiving prescribed medication for epilepsy?  Yes  No If so, specify \_\_\_\_\_

**Heart Condition**  Yes  No If so, explain: \_\_\_\_\_

Are you presently receiving prescribed medication for this condition?  Yes  No If so, explain: \_\_\_\_\_

**Kidney Condition**  Yes  No If so, explain. \_\_\_\_\_

Are you presently receiving prescribed medication for this condition?  Yes  No If so, explain. \_\_\_\_\_

**Do you have a physical impairment?**  Yes  No If so, explain: \_\_\_\_\_

**Are you presently receiving any other prescribed or over-the-counter medication?**  Yes  No

Specify: \_\_\_\_\_

**Please state any other medical conditions not mentioned above:**

\_\_\_\_\_

*I hereby certify that this information is an accurate representation of my medical history. Should any changes in this occur, I will notify the office immediately. In the event that I need emergency care and am unable to give my consent at that time, I hereby authorize any member of the Men and Women of Action Team to authorize any emergency medical attention that is needed.*

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

Parent or guardian (if under age 18) \_\_\_\_\_