

# MWOA STATESIDE SERVICE RELEASE FORM



1. Application for trip to: \_\_\_\_\_ Project Dates: \_\_\_\_\_
2. Name: \_\_\_\_\_ Gender: ~M \_ F
3. Address: \_\_\_\_\_  
Street, Apt. Etc. (both P.O. Box and physical address)
4. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
5. E-mail: \_\_\_\_\_
6. Home Phone: \_\_\_\_\_ Cell Ph: \_\_\_\_\_
7. Marital Status: \_ Single \_ Married Spouse Name: \_\_\_\_\_
8. 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

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 (please circle):  
Allergies, Asthma, Diabetes, Digestive Disorders, Epilepsy, Heart Condition, High Blood Pressure or Kidney Condition

**Please list below if you have any severe allergic reactions to medicines, bee stings or any other allergies.**

**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) \_\_\_\_\_