New Hope
for the nations

Medical Release Form

I ___________________________ _____________________ will be participating
FIRST NAME LAST NAME

in a missions trip to _______________ , taking place __________ __________ led
COUNTRY MONTH YEAR

by staff members and leadership of New Hope Worship Center.

New Hope staff and trip leaders have my full consent to obtain medical care for me in the event that I require medical attention for emergency and non-emergency situations. Furthermore, consent/permission is hereby given to staff and leadership on this trip to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under recommendation of qualified medical personnel).

I understand that New Hope Worship Center does not carry accident or medical insurance on participating trip attendees. I agree that my insurance company will be used for such medical care expenses and I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance. I understand that if I do not have medical insurance coverage that I am responsible for the payment of any medical bills.

Signed: ____

Date: ____________________________

If under 18 years old, signature of parent or legal guardian:

Signed: ____

Date: ____________________________

The following is a list of all medical conditions from which I suffer:

The following is a list of medications I am currently taking:

The following is a list of all medications that I am allergic to:

Signed: ____

Date: ______________________________

In case of emergency, please contact:

1. **Full name**_______________________________________

   Cell Phone: ______________________ **Phone2:** ____________________

   Relationship: ____________________________________

2. **Full name** ______________________________________

   Cell Phone: ______________________ **Phone2:** ____________________

   Relationship: ____________________________________

I am currently insured by the following medical insurance company:

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Policy #: ________________________ **Policy Holder:** ____________________

Physician Name: ____________________ **Physician Phone #:** __________________