Mission/Building Team Application and Medical Form

Name **(as it appears on Passport or ID)** _____ **Nickname** _____

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Phone _____

Preferred E-mail _____ Cell Phone _____

Occupation (Prior if retired) _____ Work Phone _____

Church _____ District _____

City _____ State _____ Zip _____

IS THIS YOUR FIRST TIME ON A MISSION TEAM? ☐ Yes ☐ No **DO YOU SPEAK** ☐ **Spanish** ☐ **French** ☐ Other

Work ability: (Please indicate your skill level: N = Novice, S = Skilled, P = Professional)

Carpenter	Cement Worker	Cooking	Electrician	Painter	
EMT	Helper	Laundry	Mason	Plasterer	
Nurse	Plumber	Site Worker			

Gifts and Talents

Medical Information: (Must be completed with your application)

If you now have or have had any of these symptoms or conditions, check "yes," underline, and use the space below to describe the problem. If not, check "no."

1. Dizziness, loss of consciousness or recurring headaches ☐ Yes ☐ No
2. Ear, nose, throat, tonsils or sinus problems ☐ Yes ☐ No
3. Impairment of sight, hearing or speech ☐ Yes ☐ No
4. Chronic cough, coughing up blood, close contact with tuberculosis, bronchitis, asthma ☐ Yes ☐ No
5. Chest pain, shortness of breath, palpitation, swelling of ankles, heart disease, heart murmur, high or low blood pressure ☐ Yes ☐ No
6. Reaction to bee stings ☐ Yes ☐ No
   Carry meds/what kind? _____
7. Sensitivities (allergies) to horse serum (tetanus anti-toxins), sulfa, penicillin, or other drugs or allergies ☐ Yes ☐ No
   Specify: _____
8. Gastrointestinal symptoms, i.e., recurring abdominal pain, diarrhea, passing of blood, stomach or duodenal ulcers ☐ Yes ☐ No
9. Severe menstrual cramps or problems ☐ Yes ☐ No
10. Albumin, sugar or blood in urine, kidney stone, frequency in urinating or other urinary difficulty ☐ Yes ☐ No
11. Muscle, joint or back pain; bursitis, arthritis, sciatica ☐ Yes ☐ No
12. Benign or malignant growth or tumor ☐ Yes ☐ No
13. Diabetes, thyroid trouble, hypoglycemia ☐ Yes ☐ No
14. Depression, anxiety, hysteria, nervousness ☐ Yes ☐ No
15. Dietary restrictions and food allergies ☐ Yes ☐ No
    Specify: _____
16. Have you ever been hospitalized? ☐ Yes ☐ No
    When and why? _____
17. Illnesses/Conditions for which you are now under treatment ☐ Yes ☐ No
    Specify: _____
18. State year(s) of occurrence of A. Hernias _____ B. Fractures _____
    C. Dislocations _____ D. Sprains/Strains _____
19. Other injuries, illnesses or disabilities: _____

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Name (as it appears on Passport or ID) _____

Medical Information (Continued)

20. All current medications: _____

21. Other possible medications: _____ ☐ Aspirin ☐ Ibuprofen ☐ Tylenol

☐ Male ☐ Female Age _____ Height _____ Weight _____

Date of Last Tetanus Booster _____ **Blood Type** _____

Family Physician _____ Telephone _____

Address _____ City/State/Zip _____

Person to be notified in case of emergency:

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone: _____

Insurance Each person should be covered by his/her own sickness and accident insurance. The Building Teams Committee carries a blanket policy for team members, but claims should first be made on personal policies.

Is team member covered by any hospital or medical care policy? ☐ Yes ☐ No

If yes, indicate name of company issuing the policy: _____

Policy / Certificate number: _____

RELEASE:

I understand the rigorous nature of participating as a member of a Building Team and that there are risks inherent in such participation. In consideration of being selected as a Volunteer Team Member, I do fully assume all risks of accidental injury and mishap, and do hereby release and forever discharge The United Methodist Church and its Agencies, including the Western North Carolina Conference Building Teams Committee and its Team Leaders from any and every right, claim or demand arising out of my participation as a Building Team Volunteer.

EMERGENCY MEDICAL CARE:

In the event that _____ (building team participant) suffers any illness or accident requiring emergency hospitalization while on this mission trip, I hereby give permission for any necessary hospitalization. I hereby give permission To the physician selected to order x-rays, routine tests, and treatment for the health of the above named. I realize that every effort will be made to contact me and/or the contact person above in case of emergency. In the event that I may not be able to be reached in an emergency, I hereby give permission to a physician to hospitalize / secure proper treatment for / order injection or anesthesia for the above named.

Team Participant Signature _____ **Date** _____

If form is for youth under the age of 18, parent/guardian must also sign.

PERMISSION FOR MINOR:

I hereby give permission for my child to attend and fully participate on the building team. I hereby sign the release and emergency medical care authorization on behalf of my child.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Work Phone _____ **Parent/Guardian Home Phone** _____ **Parent/Guardian Cell Phone** _____

REQUIRED: PASTOR'S ENDORSEMENT/SIGNATURE

I recommend the above as a person of Christian character and cooperative spirit.

Pastor's Signature _____ **Date:** _____

(Do **NOT** send checks)