Mission Trip to Piedras Negras, Mexico

Mission Trip Dates: Beginning: _____ Ending: _____

Name:_____

Address:_____

City: _____ State: ____ Zip: _____ Home Phone: _____

Birth Date: _____ Height: _____ Weight: _____

Medical Information

Physical Handicaps or Limitations:_____

Allergies/Medication you are allergic to:_____

Medication you are currently taking: _____

Your Medical Insurance Company: _____

Members Name: _____ Policy Number: _____

I do hereby release The Rohi Foundation, its staff and it's sponsor's from liability and responsibility for any injury or illness that I may incur during this short-term trip. In the event of emergency, I do hereby authorize the leaders of this trip, as agents for me, to consent to any examination, x-ray, medical, dental, or surgical diagnosis, treatment and hospital care advised and supervised by a physician, surgeon or dentist. (as appropriate) licensed to practice under the laws of the country/state, where the services are rendered, either at a doctors office or in any hospital. I do hereby release and authorize as stated above.

Signature: _____ Date: _____

Signature of Guardian (if under 18): _____Date: _____