

CONSENT FOR TREATMENT (adult)

FORM 4d

GENERAL INFO:

Your Name:						
[PLEASE PRINT]	First	Middle	Last			
Spouse's Name:						
[PLEASE PRINT]	First	Middle	Last			
Date of Birth:		Passport Number:		Passport Expires:		
Address:					City:	
State/Province:		Zip/Postal		Country:		
Daytime Phone:		Email Address:				
Cell Phone:		Evening Phone:				
Event:	<input type="checkbox"/>	Homes of Hope	<input type="checkbox"/>	Mission Adventures	Dates:	
Team Name:						

EMERGENCY CONTACT:

Emergency Contact:						
[PLEASE PRINT]	First	Middle	Last			
Relationship to You:					Emergency Phone:	

MEDICAL INFO:

Any Allergies?	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	If yes, please describe:				
Taking Medication?	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	If yes, please describe:				
Date of last tetanus inoculation:				Has childhood series of 3 DPT shots been given?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Do you have any conditions that would restrict you on this missions trip?						<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If yes, please specify:									
How would you rate your overall health condition?	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	

AUTHORIZATION AND CONSENT TO EMERGENCY MEDICAL TREATMENT

In case of a medical emergency, I hereby give YWAM permission to authorize any emergency medical treatment by a physician as he or she may deem necessary.

Signed:		Dated:	
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