Medical Form

You can fill this in online, print it off and send it in.

Or print it off, fill it in and send it to Awe Star.

Note **these particular sections within the form:**

Section 6

PROOF OF DOMESTIC INSURANCE: - be aware that if your student needs medical aid you are responsible for paying the first **$250.00**, which is the deductible, to Awe Star after your student arrives home, we will pay for it on the mission field. Our insurance and your insurance should take care of the rest if needed.

Page 4

NOTARY SEAL - the Parental Authorization Sheet must be notarized if you are under 18.

RETURN - This whole Medical form needs to be returned to Awe Star in a timely manner. We will not take you out of the country without it.

Awe Star Ministries P O Box 470265 Tulsa, OK 74147

Medical Information

Awe Star Ministries

Section1

Applicant's legal name:

Address: **City:**

State : **Zip:**

Emergency contacts

Name: Relation:

Address: City:

State: Zip: Email

Cell Phone # Home Phone # Work Phone #

Other contact

Name: Relation:

Address: City:

State: Zip: Email

Cell Phone # Home Phone # Work Phone #

Section 2

CHILDHOOD IMMUNIZATIONS: ALSO SEND US A COPY OF THE IMMUNIZATIONS/MEDICATIONS YOU GET FOR YOUR TRIP.

Polio	Yes	No	
Mumps/Measles/Rubella	Yes	No	
Tetanus	Yes	No	Year of last Tetanus
Other_____	Yes	No	
Diphtheria/Pertussis/Tetanus	Yes	No	

Section 3

MEDICAL CHECKLIST: Any ommission or misrepresentation will void your acceptance.

Physicians Release is required for any items checked yes.

Yes	No	Knee problems	Yes	No	Diabetes or hypoglycemia
Yes	No	Cancer	Yes	No	Cysts or tumors of any kind
Yes	No	Anemia or any other blood disorder	Yes	No	Asthma or chronic wheezing
Yes	No	Parkinson's disease	Yes	No	AIDS Virus or HIV
Yes	No	Convulsions, epilepsy or seizures	Yes	No	Fainting spells
Yes	No	High blood pressure/any cardiac problems	Yes	No	Kidney problems
Yes	No	Intestinal or bowel problems	Yes	No	Venereal disease
Yes	No	Gall bladder stones	Yes	No	Depression or ADD or ADHD
Yes	No	Rheumatism, arthritis, painful swollen joints	Yes	No	Prostate problems
Yes	No	Back pain, injury, surgery, scoliosis etc.	Yes	No	Menstrual disorder

MEDICAL INFORMATION

Section 4

CURRENT MEDICAL CARE AND PRESCRIPTIONS:

Do you have severe allergic reactions (ie. food, medicine, pollen, mold etc.) ? If so, to what?

Are you currently taking prescribed medication? If yes, please specify the medication and the dosage

Have you ever received treatment or counseling for alcohol or chemical abuse? ☐ Yes ☐ No

If yes, please specify when and where.

Do you have hearing or vision impairment? ☐ Yes ☐ No

If yes, please explain

SURGERIES & SERIOUS ILLNESS:

Explain & give dates

Section 5

Family Medical History:

Do your grandparents, parents or siblings have:

Diabetes	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No

Please list any details about your personal health not covered in the preceeding questions:

Section 6

PROOF OF DOMESTIC INSURANCE:

I certify that I have domestic health insurance that will cover me/my child during the stateside portion of the mission. I hereby understand that me/my child will be covered with supplemental insurance overseas (provided in cost of trip), but that I am responsible for any medical expenses accumulated up to the $250.00 deductible or anything not covered by me/my child's domestic insurance or Overseas Insurance.

Company

Policy No.

Insurance Company Phone No.

CONSENT FOR MEDICAL TREATMENT, RELEASE AND HOLD HARMLESS

Name of applicant

I/We as the parents/guardians/adult applicant hereby authorize the staff of Awe Star Ministries Inc. to consent to and authorize for me/us the administration of any and all reasonable first-aid operations, hospitalization, in the opinion of Awe Star Ministries Inc. that becomes necessary to save or maintain the life, health or well-being of my/our child or myself. I/We agree to and shall hold harmless from any liability the sponsor Awe Star Ministries Inc. for any such determination and authorization given by them in good, after full disclosure by trained medical personnel. In the event of the inability or refusal of Awe Star Ministries Inc. as sponsors to give any such consent or authorization, I/we hereby authorize any paramedic, medical technician, doctor or nurse to take any reasonable action and to administer any reasonable medication, which in their professional opinion, is necessary to save or maintain the life, health or well-being of my/our child or myself.

Approval of Medical Treatment ☐ I accept

Date

I/We hereby release Awe Star Ministries Inc. and its agents, officers, sponsors and employees of and from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or relating to any loss, damage or injury, including death, as may be sustained by my child/myself, or to any loss, damage or injury to any property of my child/myself, while participating with Awe Star Ministries Inc. Being duly aware of the risks and hazards inherent upon participating on a mission trip with Awe Star Ministries Inc. and/or in the counseling in connection therewith, I/we hereby voluntarily assume all risks of loss, damage or injury, including death, as may be sustained by my child/myself or any property of my child/myself as far as Awe Star Ministries Inc. is concerned. I/We/My child agree to release, indemnify, hold harmless and defend Awe Star Ministries Inc. from any claim by me or my family, estate, heir or assigns arising out of my declining the Center for Disease Control's (CDC) recommended immunizations.

Approval of Hold Harmless ☐ I accept

Date

Signature_____

Parent Authorization --- Medical Release for applicant under 18 years of age. Print this, sign it, have it notarized and send in to Awe Star.

Applicant Full Name _____

Applicant Date of Birth _____/_____/_____

This release shall be binding upon the distributees, heirs, next of kin, executors and administrators of my child/myself.

In signing the foregoing release, I/we hereby acknowledge and represent:

a) that I/we have read the foregoing release, understand it and sign it voluntarily.

b) that I/we are over 18 years of age and of sound mind.

c) that I/we have had the opportunity to consult with legal consel regarding the effect of this agreement and release, should I/We so desire.

DO NOT SIGN THIS RELEASE IF YOU DO NOT UNDERSTAND OR AGREE WITH ITS TERMS.

***If both parents possess legal custody of the child, both parents' signatures are required.**

***If one parent possesses legal custody of the child- the signature of the one parent who has legal custody is required and a copy of a legal document evidencing the custody arrangement, or a notarized copy of a death certificate for a deceased parent. We apologize for any inconvenience.**

X_____ _____/_____/_____

Father's signature (if applicant is UNDER18 years of age) Date

X_____ _____/_____/_____

Mother's signature (if applicant is UNDER 18 years of age) Date

X_____ _____/_____/_____

Guardian's signature (if applicant is UNDER 18 years of age) Date

FOR NOTARY USE

State of _____ County of _____

Signed or attested before me on this day _____, 20_____

Notary Public_____

My commission expires: _____/_____/_____

Awe Star Ministries P O Box 470265 Tulsa, OK 74147

This need only be filled out if you checked YES in Section 3

PHYSICIAN'S RELEASE FORM

This student is applying to participate in a foreign mission trip through Awe Star Ministries, Inc. He/She will take part in a strenuous choreography and will be walking/hiking continuously daily. Please note that changes in typical diet and climate may also add to the intensity of the trip. Please consider these factors before you release the student medically.

Physcian's name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office #: (_____)_____

Name of Student_____

I have examined this student, his/her medical record and medical history. *(Please indicate the appropriate choice.)*

☐ I find him/her to be in adequate condition for international travel, participation in high-intensity activities and choreography in a third world country.

☐ I do not recommend this person to participate at this time.

☐ I have prescribed a medical plan for him/her to meet prior to the mission trip in order to participate in the daily itinerary during the mission trip.

Physician's signature: _____ Date: ____/____/____

If you wish to send this page privately, please fax it to (918) 664-3544. Or it may be mailed to:

Awe Star Ministries Inc. P.O. Box 470265 Tulsa, OK 74147-0265

If you have any questions please call: (918) 664-3500