FECC Short-term Mission Projects
MEDICAL AND DENTAL HISTORY
AND
LIABILITY RELEASE FORM

Do you have any medical, dental or other health condition that might affect your ability to travel and work in a country outside the United States? ___Yes ___No

If yes, please explain:

_____

Are you currently taking any medication? ___Yes ___No
If yes, please explain:

_____

I, _____, hereby authorize the sponsoring organization and its officers, board members, agents, servants, and employees to make emergency medical or dental decisions on my behalf if I am incapacitated and cannot make such decisions for myself while I am a voluntary participant in any short-term project of FECC.

I HEREBY AGREE THAT I AM SOLELY AND FINANCIALLY RESPONSIBLE FOR ANY AND ALL MEDICAL OR DENTAL CARE PROVIDED TO ME WHILE I AM A VOLUNTARY PARTICIPANT IN ANY SHORT-TERM PROJECT OF FECC, WHETHER SUCH CARE IS PROCURED BY FECC OR BY MYSELF DURING THE TERM OF SUCH PROJECT.

Signature * _____ Print Name _____

Date _____

If you choose to submit this via e-mail, please type your e-mail address here. By typing your email address, you recognize that all attached forms submitted from this e-mail address are considered signed by you.

EVIDENCE OF MEDICAL INSURANCE

Insurance Company/Medical Provider _____

Policy Number _____

Name of Insured _____

EMERGENCY CONTACT INFORMATION

In Case of Emergency, Please Notify:

Name _____ Relationship _____ Phone _____

<u>Attach copy of insurance cards:</u> Contact your provider to see if coverage is provided in the country you are visiting. We will make our best effort to reach your emergency contact person before medical or dental treatment is provided.