



United Methodist Volunteers In Mission
Southeastern Jurisdiction Office of Coordination
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MEDICAL INFORMATION & RELEASE FORM

Name _____ Work Phone _____
 Address _____ Home Phone _____
 _____ FAX _____
 Date of last physical examination _____ Email _____

Country _____ Departure Date _____ / _____ / _____
 Location _____ Return Date _____ / _____ / _____
 Project Name _____ Team Leader _____

I _____ authorize _____
 participant another adult on trip

if I am unable to do so, to consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state or country in which they practice, during the duration of the trip identified above.

Participant's Physician _____ Phone (____) _____

Medical Insurance Provider _____ Phone (____) _____

Policy Number _____

Allergies and Medications _____

Physical disabilities and health problems – indicate whether you have special needs regarding sleeping accomodatins, meals, etc.

Signature of Participant _____ Date _____ / _____ / _____

Signature of Parent _____ Date _____ / _____ / _____
 (for youth under 18)

Notarization of Medical Release Form

State of _____ County of _____
 On this _____ day of _____, _____, before me personally appeared _____
 _____ to me known to be the same person described in and who executed
 the within instrument, and who acknowledged the same to be the free act and deed thereof.

Notary Public, _____ County State of _____

Ask your physician to read the information on the back of this sheet

TO MY PHYSICIAN:

I plan to participate in a Volunteers In Mission project in _____ . I will
(location of project)

be doing manual labor outdoors in a climate that is:

[] hot and humid [] cold and damp [] other.

Health care facilities may be inadequate or nonexistent.

The Volunteers in Mission Medical Fellowship president recommends the following immunizations and prophylactic medications:

1. A diphtheria/tetanus toxoid booster if not received during the past 10 years.
2. The drug of choice of diarrhea prevention is Ciprofloxin 500 mg once a day beginning the day of travel, increasing dose to 500 mg. every 12 hours if illness occurs.
3. A gamma globulin injection or Hepatitis A vaccine series may need to be administered prior to departure in order to prevent Hepatitis A.
4. Hepatitis B vaccine is recommended for medical-dental team missionaries who may be exposed to blood.
5. Malaria prophylaxis is indicated in certain parts of the world. Recommendations for protection against malaria and other diseases may be obtained by calling the Center for Disease Control (CDC) 24 hour hotline, 404-332-4559.
6. In most countries where UVMIM teams serve, use of a sunscreen with an SPF factor of 30 is recommended.

Please sign below if you agree that my general health is adequate for this endeavor. If you are not familiar enough with my physical health, I agree to have a physical examination and laboratory tests if indicated as part of my application process.

After reviewing the above information and knowing the team member, it is my opinion that no untoward risks would be incurred by this person's participating in a project as described above.

Signed: _____, M.D. Date: _____

Physical examination performed? ____ Yes ____ No

Print Name: _____ Phone: _____

Address _____ Fax: _____
