

WITH PEOPLEPLEASE RETRUN THESE FORMS TO THIS ADDRESS:

**ANDREW WALT
GLOBAL PIONEERS
1850 PRICE RD.
MOSCOW, TN 38057**

**PLEASE HAVE THEM IN THE MAIL NO LATER THAN
APRIL 15, 2009**

THANK YOU!

PLEASE FILL OUT THESE FORMS AND RETURN THEM TO THE OFFICE OF GLOBAL PIONEERS ALONG WITH A CLEAR COPY OF YOUR PASSPORT PICTURE AND A COPY OF YOUR OVERSEAS MEDICAL INSURANCE. (Check with your insurance company, if you do not have overseas insurance log on to www.travelinsured.com OR www.specialtyrisk.com)

BACKGROUND HISTORY

*If you answer "Yes" to any of the following, please give a complete explanation below and/or on a separate sheet. Please include date of last involvement or episode and length of involvement or episode.

Have you ever:

- Been expelled from school? Yes No
- Served time in a detention center or jail? Yes No
- Currently on trial for or been convicted of a crime? Yes No
- Been involved with tobacco products? Yes No
- Been involved with alcohol? Yes No
- Been involved with illegal drugs? Yes No
- Been involved with gang-related activities? Yes No
- Been involved with a cult or the occult? Yes No
- Had diabetes or hypoglycemia? Yes No
- Taken medication for behavior? (Please list below) Yes No
- Had seizures? Yes No
- Had fainting spells? Yes No
- Had an eating disorder? (Please list details below) Yes No
- Had breathing problems? Yes No
- Had psychiatric care? Yes No
- Involved in homosexual activities? Yes No
- Have any physical impairment? Yes No
- Had problems entering or exiting the U.S.? Yes No

Explain: _____

I have read and understand the above information. The information I have given Global Pioneers is accurate and true to the best of my knowledge.

I also give Global Pioneers the right to use my picture, voice and/or testimony in any form or promotional or advertising materials. **My enclosed signature (and signature of my parent or legal guardian if I am under the age of 18) signifies my approval of all limitations listed above.**

Signed _____

Date ____/____/____

Parent Signature _____

Date ____/____/____

MEDICAL FORMS

Page 1

THIS DOCUMENT MUST BE COMPLETED IN FULL

CONSENT FOR MEDICAL TREATMENT; RELEASE AND HOLD-HARMLESS FOR TRAVEL

1. Pioneer's Name: _____ Birth date: ____/____/____
Social Security # ____-____-____

2. WHEREAS, (I, or my child) _____, wishes to be a member of a Global Pioneers Summer Mission's Camp

3. which will be traveling to and staying in South Africa and Mozambique and WHEREAS, certain circumstances may occur resulting in (my child's, my) need for medical/dental care and treatment, and further resulting in my inability to personally give consent for such care and treatment; THEREFORE, In consideration of permission from Global Pioneers for (my child, myself) to participate in said **summer missions camp**,

4. I, _____, being of legal age, authorize Global Pioneers, or any **designated** agent of Global Pioneers, to act on (my child's, my) behalf should I be unable to do so and to consent to **all** medical/dental care and treatment, including but not limited to diagnostic test, x-ray examination, anesthesia, surgery or other procedures which **Global Pioneers** deems necessary for (my child's, my) medical well-being for the duration of the summer missions camp. This consent is given in advance of any specific diagnosis, treatment, surgery or medications, and is given to provide authorization and specific consent for medical/dental treatment and care in (my child's, my) behalf. Any consent by Global Pioneers shall have the same force and effect as if I had personally given the consent.

5. I certify I have personal health insurance, **including foreign countries, with no territorial limitation, for the providing of medical services to (my child, me)** which will provide coverage for (my child, me) during the duration of said camp. I understand that Global Pioneers provides no health plan.

Company (**Must provide copy of medical insurance**)

Policy #

(_____) _____
Insurance Company Phone Number

I hereby release Global Pioneers, its agents, servants, employees and assigns for any and all damages, liability or costs resulting from the authorizing of medical treatment on (my child's, my) behalf under the terms of this consent. I further hold Global Pioneers harmless for any and all costs, damages or expenses incurred by Global Pioneers as a result of any claim or action filed by any party alleging damages incurred as a result of any medical treatment provided or authorization for treatment provided. I understand that this release and identification releases treatment for the conduct of Global Pioneers and its agents, servants, employees or assigns even if such conduct is negligent.

In case of emergency, Closest Family Contact:

Name _____ Phone # (____) _____

Address _____ Phone # (____) _____

City _____ State or Province _____ Zip _____

Second Contact:

Name _____ Phone # (____) _____

Address _____ Phone # (____) _____

City _____ State or Province _____ Zip _____

MEDICAL FORMS

Page 2

Please complete the following questions:

- Are you currently taking any prescribed medication? Yes _____ No _____
If yes, please specify the medication and the dosage: _____
- Are you currently using any non-prescription drugs on a regular basis? Yes _____ No _____
If yes, please specify: _____
- Have you ever received treatment or counseling for alcohol or chemical abuse? Yes _____ No _____
If yes, Please specify when and where: _____
- Are you presently under a physician's care for any illness? Yes _____ No _____
If yes, Please explain: _____
- What was the date of your last physical exam and who was the Physician? _____
- Are you a vegetarian? Yes _____ No _____
If yes, how long? _____ Please know that you may need to eat meat as part of cultural sensitivity!

Please list all surgical operations or hospitalizations you/your child has undergone.

1) Operation, illness _____
Reason _____ Date _____

Name and address of hospital _____

Name of physician _____

Remaining effects _____

2) Operation, illness _____

Reason _____ Date _____

Name and address of hospital _____

Name of physician _____

Remaining Effects _____

3) Please provide any details pertaining to your health not covered by the above questions.

ALL QUESTIONS MUST BE ANSWERED. ANY MISREPRESENTATION WILL VOID YOUR ACCEPTANCE.					
YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Chronic wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling treatment
<input type="checkbox"/>	<input type="checkbox"/>	Any other respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Cysts or Tumors of any kind	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, epilepsy or seizures
<input type="checkbox"/>	<input type="checkbox"/>	Chronic or persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Skin disorder other than acne	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or any other blood disorder
<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Serious bodily injury
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or Hypoglycemia (low blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid ailment
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory trouble	<input type="checkbox"/>	<input type="checkbox"/>	Severe allergic reactions
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Any other disease, disability, or deformity not listed above
<input type="checkbox"/>	<input type="checkbox"/>	Hearing or Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>	AIDS virus or HIV
<input type="checkbox"/>	<input type="checkbox"/>	Intestinal or bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	Persistent, recurring indigestion, stomach or duodenal ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Metabolism
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder stones or colic
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism, Arthritis, painful swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Severe knee problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast or menstrual disorder, venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure / any cardiac problems			

****PLEASE NOTE THE FOLLOWING – IF YOU CHECKED “NO” TO ALL THE QUESTIONS ABOVE YOU ARE NOT REQUIRED TO COMPLETE THE DOCTOR’S RELEASE FORM ON THE 4th PAGE.**

IF YOU CHECKED “YES” TO ANY OF THE ABOVE QUESTIONS, YOUR ACCEPTANCE WILL BECOME VOID IF THESE STEPS ARE NOT FOLLOWED:

- 1) VISIT WITH YOUR DOCTOR
- 2) HAVE HIM / HER COMPLETE AND SIGN THE DOCTOR’S RELEASE FORM ON THE 4th PAGE.

MEDICAL FORMS

Page 3

MEDICAL RELEASE: (ALL APPLICANTS MUST COMPLETE ENTIRELY WITH NOTARIZATION. If you are under 18, a parent or guardian must complete the following for you. REMEMBER TO PRINT FULL NAME OF PIONEER CLEARLY IN ALL BLANKS)

I FURTHER AUTHORIZE FOR (MYSELF, MY CHILD) _____ (print name clearly in blanks),
GLOBAL PIONEERS TO:

- RELEASE ANY AND ALL OTHER MEDICAL INFORMATION OR RECORDS TO ANY PARTY DEEMED NECESSARY BY GLOBAL PIONEERS, ITS AGENTS, SERVANTS, EMPLOYEES
- ASSIGN FOR THE PROVIDING OF MEDICAL TREATMENT TO _____ OR TO MEMBERS OF THE SUMMER MISSIONS CAMP
- TO INSURE PROPER PLACEMENT OF _____ IN SUCH GROUP

I AM AWARE THAT SERIOUS ILLNESS OR INJURY MAY OCCUR ON A SUMMER MISSIONS CAMP AND THAT SUCH ILLNESS AND INJURY MAY RESULT IN (MY CHILD, MYSELF) INCURRING COSTS, EXPENSES, AND DAMAGES FOR WHICH I AM SOLELY RESPONSIBLE INCLUDING, BUT NOT LIMITED TO, RETURN OF (MY CHILD, MYSELF) BY AIR AMBULANCE OR OTHER EXTRAORDINARY MEANS AT A COST OF \$10,000 OR MORE.

I HEREBY RELEASE AND HOLD HARMLESS GLOBAL PIONEERS, ITS OFFICERS, EMPLOYEES, AND REPRESENTATIVES / VOLUNTEERS FROM ALL LIABILITY FOR PERSONAL INJURY, INCLUDING DEATH, AS WELL AS ALL PROPERTY DAMAGE OR LOSS ARISING OUT OF _____'S PARTICIPATION IN THIS CAMP. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. THE INFORMATION I HAVE GIVEN GLOBAL PIONEERS IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

I ALSO GIVE GLOBAL PIONEERS THE RIGHT TO USE _____'S PICTURE, VOICE AND/OR TESTIMONY IN ANY FORM OF PROMOTIONAL OR ADVERTISING MATERIALS. MY ENCLOSED SIGNATURE SIGNIFIES MY APPROVAL OF ALL LIMITATION LISTED ABOVE. MY SIGNATURE INSURES THAT ALL INFORMATION ON THESE FORMS IS COMPLETELY TRUE AND HAS NOT BEEN ALTERED IN ANY WAY.

X _____
Pioneer's signature Date

X _____
Father's signature Date

X _____
Mother's signature Date

***If you are in the legal custody of both parents - Required: both parents' signatures

***If you are in the legal custody of one parent - Required: the signature of the one who has legal custody and a copy of a legal document evidencing the custody arrangement, or a notarized copy of a death certificate for a deceased parent.

FOR NOTARY

*Note to notary: If you do not have a notary stamp we need other proof of notary such as a copy of notary certificate.

9. State of _____, County of _____.

Before me, the undersigned, a Notary Public in and for said county and state on _____, 200__, personally appeared the identical person who executed the within and forgoing instrument, and acknowledged to me that he/she executed the same as his/her free and voluntary act and deed, for the uses and purposes therein set forth. Given under my hand and seal of office the day and year above written.

NOTARY STAMP

My commission expires ___/___/___

Doctor's Release Form

Complete this form only if you checked 'yes' to any of the questions on the medical checklist.

In the past Global Pioneers has had people who have experienced difficulty participating in the daily camp/mission activities. The Pioneer will be involved in challenging activities and extended periods of walking and hiking as part of the daily itinerary. Dietary and climate changes also add to the physical intensity of our trips. Please consider of these factors.

Doctor's Name _____
Address _____
City _____ State _____ Zip _____
Work # (____) _____

Pioneers's name _____
Address _____
City _____ State _____ Zip _____
Phone # (____) _____ Work # (____) _____

Sex: ____M ____F Weight _____ Height _____

Blood Pressure: _____ (Optional)
Social Security Number: _____ - _____ - _____
Age: _____ Birthday: ____/____/____

I have reviewed this patient's **Medical Information, Checklist Form and Medical History**, and I have performed a physical exam. *(Please indicate the appropriate choice)*

- I find him/her to be in adequate condition for international travel and /or participation in high-intensity activities in a third world country.
- I have prescribed a medical plan of action for him/her to meet prior to the summer mission camp in order to participate in the daily itinerary during the camp.
- I do not recommend this person to participate at this time.

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