MWOA International Service Release

1. Application for trip to:________________________________ Project Dates:______________
2. Skills and Abilities: ____
3. Name: *(as it appears on passport)* __________________________________ Gender: _ M _ F
4. Address: ____
   Street, Apt. Etc. (both P.O. Box and physical address)
5. City: ________________________________ State: ______________ Zip:_____________
6. E-mail: __________________________________ Home Phone:______________________
7. Work Ph: __________________ Fax: ______________ Cell Ph: ____________________
8. Your Birth Date: ________________ Citizenship: ________________ (City, State and County of Birth)
9. Place of Employment: ____
   City: _____________________________ State: _____________ Zip: ________________
10. Have you ever traveled outside the U.S. and Canada? If so, where? _________________________
11. Do you have a passport? _Yes _No Passport Number:_____________________________
12. What country: ___________ Where was it issued? ______________ Expiration date:__________
13. Marital Status: _ Single _ Married Spouse Name: _____________________
14. IN CASE OF EMERGENCY, PLEASE NOTIFY:

    Name: ____ Relationship: ________________

    Daytime Phone: _______________ Evening Phone: ______________ Cell Ph: ______________

    Street Address: _________________________City: ________________ State: ____ Zip: _____

I, ____________________________________(your name), as a volunteer understand and am aware of the risk associated therewith and voluntarily assume such risks as a volunteer by participating in and aiding the Men and Women of Action in rendering service to this project. If accepted as a member of this MWOA team, I agree to: Release and discharge the organizations and individuals which helped make these arrangements, including the MWOA, Int'l Church of God, their agents, employees, officers and volunteers from all claims, demands, actions, judgments or executions that I have ever had, or now have, or may have, or which my heirs, executors, administrators, or assigns may have or claim to have, against these organizations, their agents, employees, officers and volunteers, and their successors or assigns, for all personal injuries, known or unknown and injuries to property, real or personal, caused by, or arising out of this journey. I intend to be legally bound by this statement.

SIGNATURE: ____DATE: ________________

Men and Women of Action, 1510 Stuart Rd. NE Suite 209, Cleveland, TN 37312
Ph: 423-478-7955 E-mail: msteve@cogmwoa.com

MEDICAL HISTORY FORM

Men and Women of Action 1510 Stuart Rd. NE Suite 209 Cleveland, TN 37312
Phone: (423) 478-7955 E-mail: msteve@cogmwoa.org

DATE: ______________________
FAMILY PHYSICIAN: ______________________
Phone # ______________________

I Have Medical Insurance: YES NO
If so, Name of Insurance Company: ______________________

Please provide the following information:
Do you have, or have you ever had any of the following medical conditions:

Allergies **Yes** **No** If so, allergic to what? ______________________
Are you presently receiving prescribed medication for allergies? **Yes** **No** If so, specify ______________________

Asthma **Yes** **No** Are you presently receiving a prescribed medication for asthma? **Yes** **No** If so, specify

Diabetes **Yes** **No** Are you presently taking insulin or other medication? **Yes** **No** If so, specify

Digestive Disorders (stomach, colon, etc.) **Yes** **No** What type? ______________________
Are you presently receiving prescribed medication for this disorder? **Yes** **No** If so, specify ______________________

Epilepsy **Yes** **No** Are you presently receiving prescribed medication for epilepsy? **Yes** **No** If so, specify

Heart Condition **Yes** **No** If so, explain: ______________________
Are you presently receiving prescribed medication for this condition? **Yes** **No** If so, explain:

Kidney Condition **Yes** **No** If so, explain. ______________________
Are you presently receiving prescribed medication for this condition? **Yes** **No** If so, explain.

Do you have a physical impairment? **Yes** **No** If so, explain: ______________________

Are you presently receiving any other prescribed or over-the-counter medication? **Yes** **No**
Specify: ______________________

Please state any other medical conditions not mentioned above:

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I hereby certify that this information is an accurate representation of my medical history. Should any changes in this occur, I will notify the office immediately. In the event that I need emergency care and am unable to give my consent at that time, I hereby authorize any member of the Men and Women of Action Team to authorize any emergency medical attention that is needed.

Signature ______________________ Date ______________________

Parent or guardian (if under age 18) ______________________