Name______________________
Trip________________________

BLUE FORMS

PLEASE MAKE COPIES OF THESE FORMS AND MAIL ORIGINALS TO JSMI OFFICE

***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:____
____
____
____

MINISTRY EXPERIENCE

Do you have any drama experience? YES NO
If yes, please explain: ____
Please rate your drama skills on a scale from 1-10_________
Do you have any children's ministry experience? YES NO
If yes, please explain: ____
Have you ever been or would like to be a clown for Children's ministry? YES NO
Do you feel comfortable speaking in front of large groups? YES NO
Do you have any experience preaching? YES NO
If yes, please explain: ____

I have read and understand the above information. The information I have given J.S.M.I. – John Smithwick Ministries International is accurate and true to the best of my knowledge.

I also give J.S.M.I. the right to use my picture, voice and/or testimony in any form for 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 ____/____/____
(Required if applicant is under the age of 18)

THIS DOCUMENT MUST BE COMPLETED IN FULL

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

1. Missionary's Name: ____ Birth date:______/______/_______
Social Security # _______-_______-_________

2. WHEREAS, (I, or my child) _____________________________, wishes to be a member of a J.S.M.I. – John Smithwick Ministries International missionary group

3. which will be traveling to and staying in _______________________ (country) 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 J.S.M.I.** for (my child, myself) to participate in said **missionary group,**

4. I, ____________________, being of legal age, authorize J.S.M.I., or any **designated** agent of J.S.M.I., 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 **J.S.M.I. deems** necessary for (my child's, my) medical well-being for the duration of the mission. 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 J.S.M.I. 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 mission. I understand that J.S.M.I. provides no health plan.

____ ________________________
Company **(Must provide copy of medical insurance card)** Policy #

(_____)___________________________________
Insurance Company Phone Number

I hereby release J.S.M.I., 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 J.S.M.I. for any and all costs, damages or expenses incurred by J.S.M.I. 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 J.S.M.I. and its agents, servants, employees or assigns even if such conduct is negligent.

Closest Family Contact(s)
Name ____ **Phone # (_____)** _______________________
Address ____ **Phone # (_____)** _______________________
City _____________________________________ **State or Province** ____________ **Zip** _________________
Relationship______________________________

In case of emergency, Second Contact:
Name ____ **Phone # (_____)** ______________________
Address ____ **Phone # (_____)** _______________________
City _____________________________________ **State or Province** ____________ **Zip** _________________
Relationship______________________________

CHILDHOOD IMMUNIZATIONS (These must be up-to-date, please do not leave blank.)

Yes	No	Type	Year Administered	Yes	No	Type	Year Administered
___	___	Mumps/Measles/Rubella	_____________	___	___	Tetanus	__________
___	___	Diphtheria/Pertussis/Tetanus	_____________	___	___	Other__________	__________
___	___	Polio	_____________				

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 be aware that you may need to eat meat as part of cultural sensitivity!

Please list all surgical operations or hospitalizations you/your child have 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**	
		Asthma or Chronic wheezing			Mental Health Counseling treatment
		Any other respiratory problems			Fainting spells
		Cysts or Tumors of any kind			Convulsions, epilepsy or seizures
		Chronic or persistent cough			Parkinson's Disease
		Skin disorder other than acne			Anemia or any other blood disorder
		Goiter			Serious bodily injury
		Diabetes or Hypoglycemia (low blood sugar)			Thyroid ailment
		Circulatory trouble			Severe allergic reactions
		Cancer			Any other disease, disability, or deformity not listed above
		Major Hearing or Vision Impairment			AIDS virus or HIV
		Intestinal or bowel problems			Persistent, recurring indigestion, stomach or duodenal ulcers
		Kidney problems			High or Low Metabolism
		Tuberculosis			Gall bladder stones or colic
		Rheumatism, Arthritis, painful swollen joints			Prostate problems
		Severe knee problems			Breast or menstrual disorder, venereal disease
		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 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 MISSIONARY CLEARLY IN ALL BLANKS)*

I FURTHER AUTHORIZE FOR (MYSELF, MY CHILD)_________________________________ (print name clearly in blanks):
J.S.M.I. – JOHN SMITHWICK MINISTRIES INTERNATIONAL TO:

- RELEASE ANY AND ALL OTHER MEDICAL INFORMATION OR RECORDS TO ANY PARTY DEEMED NECESSARY BY J.S.M.I., ITS AGENTS, SERVANTS, EMPLOYEES
- ASSIGN FOR THE PROVIDING OF MEDICAL TREATMENT TO _____________________________ OR TO MEMBERS OF THE MISSIONARY GROUP
- TO INSURE PROPER PLACEMENT OF_______________________________ IN SUCH GROUP

I AM AWARE THAT SERIOUS ILLNESS OR INJURY MAY OCCUR ON A MISSION TRIP AND THAT SUCH ILLNESS AND INJURY MAY RESULT IN (MY CHILD, MYSELF) ICURRING COSTS, EXPENSES, AND DAMAGES FOR WHICH I AM SOLELY RESPONSIBLE INLUDING, 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 J.S.M.I. – JOHN SMITHWICK MINISTRIES INTERNATIONAL, ITS OFFICERS, EMPLOYEES, AND REPRESENTATIVES / VOLUNTEERS FROM ALL LIABILITY FOR PERSONAL INJURY, INLUDING DEATH, AS WELL AS ALL PROPERTY DAMAGE OR LOSS ARISING OUT OF______________________________'S PARTICIPATION IN THIS TRIP. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. THE INFORMATION I HAVE GIVEN J.S.M.I. IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

I ALSO GIVE J.S.M.I. – JOHN SMITHWICK MINISTRIES INTERNATIONAL 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.

6. X___________________________________ _______
Missionary's signature Date

7. X____________________________________ _________
Guardian's signature (if applicant under 18) Date

8a. X__________________________________ _______
Father's signature (if applicant under 18) Date

8b. X___________________________________ _________
Mother's signature (if applicant under 18) 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 on ___/___/___

DOCTOR'S RELEASE FORM

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

In the past J.S.M.I. – John Smithwick Ministries International has had people who have experienced difficulty participating in the daily mission activities. The missionary will be involved in challenging drama training (choreography) 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 be considerate of these factors.

Doctor's Name ____
Address ____
City __________________________ State _________ Zip ____
Work # (___) ___________________

Missionary'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, participation in high-intensity activities and choreography in a third world country.
- ☐ I have prescribed a medical plan of action for him/her to meet prior to the mission trip in order to participate in the daily itinerary during the mission trip.
- ☐ I do not recommend this person to participate at this time.

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