



**ONE TEAM INTERNATIONAL  
SAINT LOUIS PROJECT  
Medical and Liability Release Form**  
(Bring with you at time of registration)

I, as parent/guardian of \_\_\_\_\_, release the host church, its agents, and employees, and One Team International LLC from any claims illness or causes of action arising from or connected with transportation to and from, attendance, and participation in the St. Louis Project, Sunday, June 13th - Friday, July 18th. I further agree that the host church, its agents or employees, and One Team International are authorized to provide such medical care treatment as may be necessary, in their judgment, during such transportation and project.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If parents cannot be reached, please contact:

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Phone: \_\_\_\_\_

**1. Health History:** (Check where appropriate. Please also give approximate dates.)

Bleeding/Clotting disorders     Frequent ear infections     Mononucleosis  
 Chicken Pox                       Hearing defect/disease     Psychiatric Treatment  
 Convulsions                         Hepatitis                       Tuberculosis  
 Diabetes                               Hypertension                 Other: please explain

In the event that your student becomes ill, are there any other medical contentions of which we should be concerned? [  ] Yes [  ] No

If yes, please describe:

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You may choose to call your Pastor and discuss the conditions personally rather than give this information on this form. Your privacy will be respected.

**2. Known Allergies** [  ] Yes [  ] No If yes, please check known allergies.

Asthma     Insect Stings     Penicillin  
 Hay Fever     Ivy Poisoning, etc.     Other:

**3. Physical Disabilities** [  ] Yes [  ] No If yes, what?

**4. Regular Medication** [  ] Yes [  ] No If yes, what?

**5. Is your Student under a physician's care at this time?**

[  ] Yes [  ] No If yes, you will need to provide a statement from your physician telling of the medications, special diet, restrictions as to recreation activities, etc.

**6. In case of emergency,**

please check one: [  ] Call before treating. [  ] Give First Aid, then call.

**7. Immunizations up to date** [  ] Yes [  ] No if no, please indicate reason:

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Date of last tetanus shot: \_\_\_\_\_

**INSURANCE:**

*All participants must provide their own health insurance as the primary source of coverage. One Team International, and its partners will provide no medical, health, life or other insurance to participants.*

Hospital Insurance:  Yes  No

Insurance Company:

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Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

**PICTURE & VIDEO RELEASE**

I give permission for my child's image through print and video to be used in promotion for future One Team International Events.

Signature: \_\_\_\_\_