TCM INTERNATIONAL INSTITUTE, INC. (TCM)

Medical Information and Consent Form for Volunteers

Please complete this form and return it to the church's trip coordinator or the TCM Indianapolis office so it can become part of the permanent file if you serve with TCM in Austria.

Medical conditions could affect your mission trip. This form is to aid you in making your decision, as to whether you are physically and mentally able to travel internationally and serve with TCM in Austria. TCM may also use this information to advise and assist you with special needs or in the event of an emergency abroad.

Due to the physical demands required for serving with TCM in Austria, TCM requests that all volunteer workers be in good to excellent health. The workdays are long, roughly an 11 to 12 hour overall schedule with a break in the afternoon. Work responsibilities will include lots of walking, stairs, lifting, standing, and other repetitive activities. If you determine it will be difficult for you physically, TCM would ask that you reconsider and perhaps sponsor another person to come in your place.

TCM strongly recommends that you seek the advice of your primary care physician and any specialty care physicians for specific implications regarding your physical and mental condition before undertaking this mission trip. If your physician advises against international travel and or a mission trip, it is wise to heed his/her advice.

TCM staff will treat the information collected on this form as confidential and will use reasonable measures to protect your privacy.

GENERAL INFORMATION

Name: Sex: ▫ Male ▫ Female

Address: Date of Birth:

City: State and ZIP:

Telephone: E-mail:

EMERGENCY INFORMATION-Please write legibly

Contact & Relationship: Telephone:

E-mail: City and State:

If attempts to reach the person above are unsuccessful, please contact my primary care physician:

Doctor: Telephone:

E-mail: City and State:

HEALTH INFORMATION

▫High Blood Pressure	▫Asthma	▫Insect Sting Reaction
▫Food or Drug Allergies	▫Hay Fever	▫Diabetes or Hypoglycemia
▫Nervous Disorder	▫Emotional Conditions	▫Physical Disability
▫Epilepsy	▫Seizure Disorder	▫Psychological Conditions
▫Heart Problems	▫Chemical Sensitivities	▫Other:

If you have checked any of the items above, please give specific details below or on a separate sheet of paper:

Have you had any type of medical surgery or procedure, including out-patient care, in the last 6 months? If so, please give specific details below or on a separate sheet of paper:

Are you able to move up and down stairs and perform routine lifting? If not, please explain physical restrictions and/or limitations.

Will you be taking any type of medication during the time you anticipate being in Austria with TCM? If so, please list **medication** and the **condition** for which it is prescribed.

Do you have any physical or medical restrictions on physical activity? If so, please describe.

Did you consult your primary care physician before agreeing to come on this mission trip? If so, did they give you their consent?

INSURANCE INFORMATION:

Policyholder: Policy Number:

Medical Insurance Company: Telephone:

CONSENT TO MEDICAL TREATMENT AND CONSENT TO DISCLOSE MEDICAL INFORMATION:

I authorize TCM to provide to me, through medical personnel of their choice, customary medical assistance, transportation, and emergency medical services should I require such assistance, transportation, or services as a result of injury or damage related to my participation in the mission trip. This consent does not impose a duty upon TCM to provide such assistance, transportation, or services. In addition, I give my consent to TCM to disclose such medical information to medical personnel treating me for emergency medical services. I understand that information disclosed to third parties per this authorization may be re-disclosed by those third parties and I release TCM from liability resulting from such third party disclosures. In addition, if I do receive emergency medical services during the Program, I give my consent to TCM to disclose the status of my condition and treatment to my family.

Signature: _____ Date: _____