

International Missions Aid: IMA

Individual Information Waiver Form

PLEASE PRINT: Trip Location: _____ **Team Leader:** _____ **Dates of Trip:** _____

Name: _____

Address: _____

City: _____ State/Prov _____ Zip: _____

Cell Phone: (____) _____ **Home Phone:** (____) _____ **Date Of Birth:** _____

Preferred E-Mail: _____

MEDICAL HISTORY INFORMATION: Chronic or Recurring Illnesses:

_____ Allergies to medications, foods, insect stings or other: _____ (Please attach Medication List) Special medication (name it) and how it is given: _____ Visit the Center for Disease Control at www.cdc.gov. for recommended shots. It is your responsibility to check and be current.

In case of an emergency please notify: _____ Phone # _____

I AGREE TO THE FOLLOWING:

I the undersigned participant (_____), hereby and agree not to hold IMA, its officers, employees, or other agents liable for any injury, loss, damage, or accident, delay, or irregularity in schedule that might be while on one of their Mission Trips or while working, training, or participating in any activities at any IMA location. Permission is granted and agreed to attend/participate in activities sponsored/instructed by staff.

I realize and acknowledge that my participation on a Mission Trip or any other activities sponsored by IMA in the United States or any foreign country includes many risks and possible dangers. I am well aware that travel in the United States and foreign countries exposes me to such risks as accidents, disease, war, political unrest, injury from construction projects, and other calamities and I therefore do not hold IMA, liable.

I hereby assume any such risks that might result from travel in the United States or any foreign country, and I unconditionally agree NOT to hold IMA, its officers, employees, or other agents blameless for any liability concerning personal health, well-being, or any liability for my personal property that might be lost, damaged, or stolen while participating on a mission trip.

I authorize an adult to whose care I have been entrusted to consent to any emergency medical/surgical procedure and to obtain medical prescriptions as necessary due to accident or illness, by a licensed physician or dentist. I will assume the responsibility for all medical bills, if any.

Further, should it be necessary for me to return home, due to medical reasons, disciplinary action or otherwise, I hereby assume all

responsibility and transportation costs.

Attached is a copy of trip participant's insurance card or a statement that you do not hold current insurance; please attach to this signed form. Failure to do so may terminate trip.

By signing below, I understand I will represent IMA and obey the rules of the organization; I further release my pictures and video footage for their use.

Signature: _____ **Date:** _____

(Applicant and Parent/Guardian if Minor)

Signature: _____ **Date:** _____

Email: imatrips01@gmail.com Web: IMAServant.com