Catch THE VISION International

All Participants

Liability Release Form

Catch the Vision International should make copies for each participant

We reserve the right to refuse anyone who does not have a CTVI liability release form signed by the proper individual, and/or parent or guardian

If you or your child has existing medical limitations, including allergies, which would affect or limit you or your child's participation in any mission activity, or of which medical personnel should be aware of, please indicate below. Without such notice, it will be assumed that you or your child is physically fit and mentally capable of participation in ALL activities.

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** Please notify the leader of your group of any medical limitations or special needs.

**The leader of your group will be responsible for taking care of these special needs.

Catch the Vision International including employees and representatives of the aforementioned organization shall be held harmless from any suit, action, damages, or claims at law or otherwise resulting from or arising out of any injury, accident, or illness which may befall on ____and

NAME OF PARTICIPANT

His/her property while on mission with CTVI. If the participant is a minor, this covenant is applicable to the participant and his/her parents or guardian.

The undersigned parent or guardian hereby authorizes Catch the Vision international (CTVI) or employee to take such action as may be necessary for the medical care or treatment including the administration of medication, permission for surgery, or other such action as needed in the vent of injury or illness of participant or when parent or guardian cannot be reached for authorization. In the event the authorized person refuses or is not able to act, CTVI personnel are authorized as set forth above. This authorization may be presented to medical personnel without liability of said personnel to seek further authority. I understand that as a participant, my child may be photographed or videotaped during normal mission activities and these photos/videos may be used in promotional materials. I authorized my child to share or not to share their email address with CTVI for future mission updates.

____/________________________________Date______________________

SIGNATURE OF PARENT/GUARDIAN PRINT

____/________________________________Date______________________

SIGNATURE OF PARENT/GUARDIAN PRINT

If participant is under 18 years of age

1425 Russell Street, Orangeburg, SC 29115
p: 803-539-2301, ext. 2 f: 803-531-8509

PARENTAL CONSENT & MEDICAL AUTHORIZATION

Parents and legal guardians of students are asked to complete this form and return it to CTVI. The information is designed to assist CTVI in providing for the safety of your student during CTVI sponsored activities. Its consent is considered confidential and will be used only by those adults who have charge of activities in which your student participates.

General Information (please print) Last Grade Completed: ________________ Date of Birth:_____________________

Individual's Name: ____

Street Address: ____

City:______________________________State:____________Zip:______________

Individual's Gender: ❑ MALE ❑ FEMALE

Individual's Hair Color:_________ Eye Color: ________Height:________

Individual's Cell Phone: ________________________ EMAIL ____________________________

T-Shirt Size (please circle one) Youth: S M L XL Adult: S M L XL

Parent/Guardian Name: _________________Phone: (w) ___________

Parent/Guardian Email Address: ____________________________________

Parent/Guardian Phone (h) ______________________ (c) ______________________

Emergency Contact 1:

____

Relationship to Individual: ______________________ Phone: ______________________

Emergency Contact 2:

____

Relationship to Individual: ______________________ Phone: ______________________

Individual's Physician: ______________________ Phone: ______________________

Individual's Insurance Carrier & Policy Number: ______________________________

Name of Primary Insured: ____________________________________

Health History (please check all that apply)

❑ Asthma ❑ Seizures ❑ Emotional/Behavioral ❑ Disability ❑ Cardiac

❑ Digestive ❑ Sleep Disturbances ❑ Disorders ❑ Disorders ❑ Diabetes

❑ Motion Sickness ❑ Vision/Hearing Impairment

❑ Mental Illness ❑ Physical Disability ❑ Appliances (retainers, contact lens)

❑ Allergies: ______________________________

❑ Other: ______________________________

If any of the above are checked, please give details:

____

____

Date of last Tetanus Shot: ____________

Does the individual require a special diet? ❑ Yes ❑ No

If yes, please explain: ______________________________

____

Does the individual use an inhaler? ❑ Yes ❑ No

Is the individual taking a prescription or non-prescription medication? ❑ Yes ❑ No

If yes, please answer the following:

1. Medication: ______________________________

   Dosage & Frequency of dosage ____________

2. Medication: ______________________________

   Dosage & Frequency of dosage ____________

3. Medication: ______________________________

   Dosage & Frequency of dosage ____________

Swimming Assessment:

Please check the level of swimming ability

___ NO swimming experience

___Completed Beginner Training course

 * date completed & Instructor: ______________________________

___Completed Intermediate Training course

 * date completed & Instructor: ______________________________

___Other, please explain: ______________________________

STATEMENT OF CONSENT

I, the undersigned, parent or legal guardian of ____

do hereby consent to any x-ray exam, anesthetic, medical diagnosis or treatment and hospital services that may be rendered to said minor, under the general or specific instructions of ____

(NAME OF CHILD'S PHYSICIAN)

or, if unavailable, to on-call physicians at a hospital or clinic. It is understood that this consent is given in advance of any specific diagnosis or treatment and is given to encourage those persons who have temporary custody of my child, in my absence, and said physician to exercise their best judgment as to the requirements of such diagnosis or said treatment.

I agree to notify Catch the Vision International in the event of any health changes that would restrict my child's participation in any normal CTVI activities. I also understand that the adult supervisors reserve the right to restrict my child from any activity that they do not feel is within the physical capability of my child.

This consent will remain effective until 31st day of December, 2019 delivered to said persons entrusted with the care, custody, and control of said minor child. I understand that any and all medical expenses incurred are my responsibility and that there is no medical insurance coverage provided by CTVI of Orangeburg.

____/_________________________________Date_____________________

SIGNATURE OF PARENT/GUARDIAN PRINT

(Do not sign except in presence of Notary)

Subscribed and Sworn to before me this___________________day of____________________20_______

Signature of Notary Public:____

My commission expires:__________________________________

Dated:_________________________________

Seal of Notary:`

Catch THE VISION International

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p: 803-539-2301, ext. 2 **f:** 803-531-8509

Photo Release Form

I, ______________________________________, give permission for CTVI to use photos and/or video of myself and/or my child on their website, for advertising/promotion, and/ or for screen presentations.

____/_________________________________Date_____________________

SIGNATURE OF PARENT/GUARDIAN PRINT

Mission Participant's Form

Mission Date: June 22-29, 2019

1425 Russell Street
Orangeburg, SC 29115
www.CatchTheVision.org

TELL US ABOUT YOU:

Name: ______________________________

Address: ______________________________

____

Email: ______________________________

Cell Phone: ______________________________

Date of Birth: ____________ Age: ________ Gender: ______

Emergency Contact:

Name: ____________ Relation: ________ Phone: ________

Name: ____________ Relation: ________ Phone: ________

Church Affiliation (optional): ______________________________

Passport #: ______________________________

Why do you want to go on this mission trip?
(*Use back side if needed*)

____

____

____

What do you plan on getting out of this mission trip?
(*Use back side if needed*)

____

____

____

How did you find out about this mission trip?

____

Mission Campus Cost $1,295

INCLUDES:

- Lodging and meals on Campus for 5 nights
- 1 night stay in airport hotel upon late night arrival.
- Church on Sunday morning at Camino de Vida.

Approximate Airfare $1,200
(We will obtain exact amount when tickets are purchased)

Lima Experience Add-On
(RECOMMENDED) = $395

- 1 nights at JW Marriott in
- Shopping and touring the city
- Group meal in Miraflores

Final payment is due on April 10, 2019.

- **$500 non-refundable deposit** needs to be mailed in with the filled out papers.
- Please return a copy of your passport and drivers license with this form.

If you have any questions please contact:

Morgan Fanning
e: morgan@catchthevision.org
p: 803.539.2301

** If you are under 18, you must have a guardian of 21 or older present on the trip*