

**iWitness Mission Team
Medical Release Form**

Name _____ Trip Dates _____

Phone _____ Sex _____ Age _____ Grade _____

Address _____ City _____ St _____ Zip _____

List any allergies and/or medications you are currently taking: _____

Parent's Name _____

Address if different from above _____

Home phone _____ Business phone _____

Family Physician _____ Phone _____

Insurance Co. Name _____

Policy # _____ Group # _____

Other person to notify in case of emergency:

Name _____ Phone _____

_____ has my permission to participate on the
iWitness Mission trip. I give iWitness Ministries and its representatives permission to see that
my child receives any medical help he/she may need while on this trip.

Parent's Signature _____ Date _____

Team Member's Signature _____ Date _____
(if over 18 years old)