

**The Global Hands of Healing, Inc.
Medical/Dental Mission Team**

Medical Consent Form

I, _____ authorize _____
(Volunteer Participant) (Another Adult on Trip)

to consent on my behalf to any necessary examination, anesthetic, medical diagnosis, surgery or other treatment, and/or hospital care rendered to me under general or special supervision and on the advise of any physician or surgeon licensed to practice medicine in the state or country in which they practice, during the duration of the trip identified below:

Mission Trip: _____

Date of Trip: _____

Participate's Physician _____ Telephone: _____

Participant's Medical Insurance: _____ / _____
(Insurance Carrier) (Policy Number)

(Carrier's Telephone Number)

Allergies or Medications: _____

Signature of Participant: _____ Date: _____

Notarization of Medical Release Form:

STATE OF _____

COUNTY OF _____

On this ____ day of _____ (year), before me personally appeared _____ to me known to be the same person described in and who executed this instrument, and who acknowledged the same to be the free act and deed thereof.

x _____
Notary Public, _____ County
State of _____
My Commission Expires _____