**Orphan Care Trip/Medical Release Form**

**Fees:**

* Application fee of $200 per person to be submitted to Children of All Nations along with trip application
* Applications are good for 1 calendar year
* Remaining $700 due at one month before scheduled travel date
* $50 per person late fee for payments submitted between 1 to 7 days late
* $100 per person late fee for payments submitted between 8 to 14 days late
* \*\*No payments will be accepted after the 14th late day and application fee will not be refunded

**Medical Information & Release**

**Copies of your insurance card** must accompany this form.

Name:      Birth Date:

Address:

City:       State:      ZIP:

Home Phone (plus area code)       Work Phone (plus area code)

Medical Insurance Provider:       ID #      Group #

Will your medical insurance cover you out of the country? Yes  No

Name of Primary Physician:

Address:

City:       State:      ZIP:

Phone (plus area code)

Emergency Local Contact:

City:       State:      ZIP:

Home Phone (plus area code)      Work Phone (plus area code)

Please check if you suffer from any of the following medical conditions

Hypertension  Hypoglycemia  Bleeding Disorders  Heart Disease

Seizures  Insect Allergies  Asthma  Chronic Anxiety

Arthritis  Diabetes  Depression Glaucoma

Migraines  Phobias – List

Physical Limitations – Please List

List any medications (prescription or OTC) taken on a regular basis:

List Medical & Food Allergies:

Blood Type       Have you had any surgery in the past three years? Yes  No

If so, please explain:

In an emergency, I give my permission to a licensed physician to hospitalize or anesthetize me, or perform surgery on me. I understand that every effort will be made to inform my emergency contact before these actions are taken.

Signature: Date:

Parent/Guardian Signature:       Date:

(only if participant is under 18 years of age)

Relationship to Participant:

Do you or anyone in your family attending the orphan care trip have any type of criminal record?

\*background checks will be ran so please be honest

Yes No If yes, please explain:

### Part Two: Emergency Contact Information

In case of emergency, CAN requires at least two different contacts:

Contact One:

Name:

Phone number:

Relationship:

Contact Two:

Name:

Phone number:

Relationship:

### Part Three: Immunization

Please list your immunizations and associated dates:

**Part Four: Medical Release/Hold Harmless, Consent, Agreements:**

**On behalf of myself/my child, I further authorize CAN:**

* Assign for providing medical treatment to myself, my child, or to members of orphan care trip

### Initial

**I hereby release and agree to indemnify** CAN, its agents, servants, employees and assigns for any and all damages, liability or costs resulting from the authorizing of medical treatment on my/my child’s behalf under the terms of this consent. I further hold CAN harmless from any and all costs, damages or expenses incurred as a result of any claim or action filed by any party alleging damages incurred as a result of any medical treatment provided or authorized for treatment provided.

### Initial

**I am aware** that serious illness or injury may occur on a mission trip and that such illness and injury may result in incurring costs, expenses, and damages for which I am solely responsible, including, but not limited to, return of myself or my child by air ambulance or other extraordinary means. I also understand that mission trips may be associated with risks of bodily harm, death, and/or damage to or loss of personal possessions resulting from, without limitation, inclement weather, transportation accident, or terrorism. On behalf of myself and my heirs, (and participant, if participant is under 18), I personally assume all such risks, whether foreseen or unforeseen by CAN or myself.

### Initial

**I hereby release** and hold harmless CAN, its officers, employees, agents, and representative/volunteers from all liability for personal injury, including death, as well as all property damage or loss arising out of participation in this trip. I understand that this release and indemnification releases liability for the conduct of CAN and its agents, servants, employees or assigns, even if such conduct is negligent.

**Initial**

**I also give** CAN the right to use my/my child’s picture, voice and/or testimony in any form of promotional or advertising materials.

### Initial

**Waiver of Mission Trip Insurance:**

I understand that CAN strongly recommends the purchase of trip Insurance. I have read all of the materials presented in this Application and Travel Release Form and choose to *not* obtain such insurance.

Signature:       Date

**Refunds if client withdraws after paying the full $900:**

1. $500 will be refunded if the scheduled travel date is more than 2 weeks away
2. $250 will be refunded if the scheduled travel date is less than 2 weeks away

\*\*Client’s flight info must be sent and approved by CAN no later than one week prior to scheduled travel date. Failure to get approval will result in an immediate void of this contract and all fees paid will be non-refundable.

**Authorization:**

I have read and understand the above information. The information I have given CAN is accurate and true to the best of my knowledge.

The parties agree that a photocopy may be used to the same extent as an original signed copy.

*If you are under 18, a parent/legal guardian must sign this form for you.*

Signature:       Date:

**Electronic Signature**

I/We understand and agree that electronic signature below and its related fields are treated by Children of All Nations like a physical handwritten signature on a paper agreement.

Signature:       Date:

**Travel Insurance**

Travel insurance is always recommended when traveling to another country. If you would like to book travel insurance through us please use the following link <https://www.worldtrips.com/quotes/atlas/?referID=23600AB> or call [800.647.4589](tel:(800)%20647-4589)

ORPHAN CARE TRIP

**Payment Authorization Form**

Please check the box next to the appropriate payment remittance type. If paying by Credit Card, please read the refund policy statement. Thank you.

Contact Information:

Children of All Nations

248 Addie Roy Road, A102

Austin, TX 78746

Phone: (512) 323-9595

Fax: (512) 323-9599

info@childrenofallnations.com

🞏 Check (Payable To: Children of All Nations)

* Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Check Number: \_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Credit Card

**By signing this Payment Authorization Form**, I verify that I choose to pay the Fee on this Payment Authorization Form by credit card. I agree and understand that this fee paid to Great Wall China Adoption d/b/a Children of All Nations, as indicated in this Payment Authorization Form is non-refundable.

Amount charged: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Visa 🞏 Master Card 🞏 Discover

###### Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Name as it appears on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: / 3-digit Security Number (CVV): \_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Driver’s License number and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_