CHILDREN'S CUP

PHYSICIAN'S RELEASE

(Valid for three years from the date of the visit as long as the patient is in good health.)

Patient Name:______________________________ Date:______________________

Dates of Mission Trip:________________________ Location of Trip:______________

List the type of activities planned for this trip: (building project, high elevations, feeding kids, etc.)

Do you have any allergies? If yes, please list.

Are you in generally good health?

Do you have any activity or medical restrictions?

Are you taking any medications? Please list name and dosage.

PHYSICIAN EVALUATION

Please review patient's information above and make additions as necessary.

Does patient have any medical conditions important to communicate in the event of a medical emergency?

Does patient have any medical limitations or restrictions that would prevent patient from participating in any planned or unexpected strenuous physical activity?

After discussing the activities of the mission trip and required international travel with the patient, do you have any concerns (with either their physical or mental health) about this patient participating in the trip?

Physician Name:_____________________________ Date:________________

Physician Signature:__________________________ Phone:______________

Physical Address:____