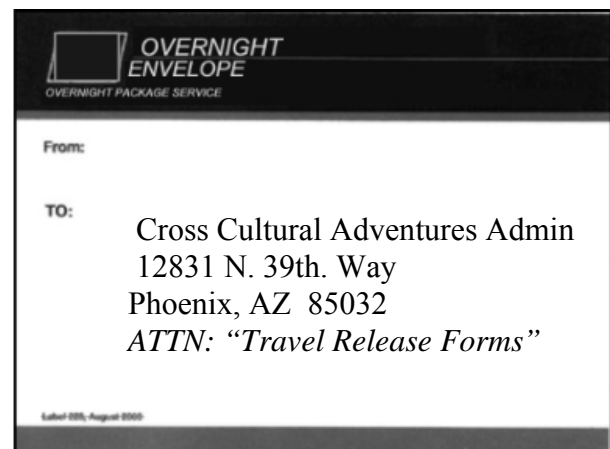


Travel Release Forms

Mailing Instructions

1. Mail your original, notarized Travel Release Forms as directed in number 4.
2. Do NOT e-mail these documents!
3. Review Travel Release Form with your CCA Representative before mailing
4. In mailing the Travel Release Forms the original, please write "Travel Release Forms" on the bottom left side of the envelope and mail to the following address:



Regular Mail

Overnight Mail l

Travel Release Form *(7 easy steps!)*

This form is REQUIRED before your 50% Deadline!

Step 1: Health Insurance

Check following 4 boxes and attach copy of insurance card to back of form.

- _____
Policy Holder's Name
- _____
Insurance Company
- _____
Policy #
(____)
- _____
Insurance Company Phone Number



Participant's Name *(last, first)* _____

ID# *(located on your acceptance letter)* _____

Country Trip Code: _____

Birth date: ____/____/____

For office use only

Date: _____

Rep: _____

Status: _____

Step 2: Emergency Contact Information

Fill out at least 2 different contacts.

In case of emergency where parents cannot be reached, contact:

Name _____ Relationship to Applicant: _____ Phone # (____) _____
 Address _____ Work Phone # (____) _____
 City _____ State or Province _____ Zip _____ Cell (____) _____

Mother/Guardian's Information:

Name _____ Phone # (____) _____
 Address _____ Work Phone # (____) _____
 City _____ State or Province _____ Zip _____ Cell (____) _____

Father/Guardian's Information (if different):

Name _____ Phone # (____) _____
 Address _____ Work Phone # (____) _____
 City _____ State or Province _____ Zip _____ Cell (____) _____

Step 3: Medical Checklist/Questions

If any box is checked below, a Medical Release Form [pg.4] is required

Medical Checklist

Please check if the participant has any of the following

<input type="checkbox"/> Asthma or Chronic wheezing	<input type="checkbox"/> Mental Health Counseling treatment/depression
<input type="checkbox"/> Any other respiratory problems	<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Cysts or Tumors of any kind	<input type="checkbox"/> Convulsions, epilepsy or seizures
<input type="checkbox"/> Chronic or persistent cough	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Skin disorder other than acne	<input type="checkbox"/> Anemia or any other blood disorder
<input type="checkbox"/> Attempted suicide	<input type="checkbox"/> Serious bodily injury
<input type="checkbox"/> Intentionally inflicted harm on oneself	<input type="checkbox"/> Thyroid ailment
<input type="checkbox"/> Diabetes or Hypoglycemia (low blood sugar)	<input type="checkbox"/> Severe allergic reactions
<input type="checkbox"/> Circulatory trouble	<input type="checkbox"/> AIDS virus or HIV
<input type="checkbox"/> Hearing or Vision Impairment	<input type="checkbox"/> High or Low Metabolism
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Gall bladder stones or colic
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Rheumatism, Arthritis, Painful swollen joints	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Severe Knee Problems	<input type="checkbox"/> Breast or menstrual disorder
<input type="checkbox"/> Intestinal or bowel problems	<input type="checkbox"/> High blood pressure/any cardiac problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Eating disorder
<input type="checkbox"/> Persistent, recurring indigestion, stomach or duodenal ulcers	<input type="checkbox"/> Any other disease or disability not listed above

If you are a vegetarian for health reasons, not preference, what are your limitations? _____

Note to vegetarians: You may need to eat meat as part of cultural sensitivity!

Medical Questions

Prescription Medication? _____ yes/no

What medication: _____

Dosage: _____

Non-Prescription Medication? _____ yes/no

What medication: _____

Dosage: _____

Allergic to any foods/med? _____ yes/no

What foods/meds: _____

Treatment/Counseling for Chemical or

Alcohol abuse _____ yes/no

When: _____

Where: _____

Under Physicians care for illness _____ yes/no

Explain: _____

Last date of physical exam? ____/____/____

Are you a vegetarian? _____ yes/no

How long: _____

Step 4: Childhood Immunization

Must list a year for each immunization. Tetanus immunization must be within the last 10 years

Type	Yes	No	Year Administered	Type	Yes	No	Year Administered
Mumps/Measles/Rubella				Polio			
Diphtheria/Pertussis/Tetanus				Tetanus (within 10 years)			

I, _____, agree that it will solely be my responsibility to obtain information on travel immunizations required/recommended and travel precautions for the area. I realize that immunizations must be completed 4-6 weeks prior to travel.

Step 5: Surgical History

Fill out all surgical history

Please list all surgical operations or hospitalizations the participant has undergone.

(For more than 2, please attach a sheet of paper.)

1) Operation, illness _____

Reason _____ Date ____/____/____

Name and address of hospital _____

Name of physician _____ Remaining Effects _____

2) Operation, illness _____

Reason _____ Date ____/____/____

Name and address of hospital _____

Name of physician _____ Remaining Effects _____

3) Please provide any details pertaining to your health not covered in this Travel Release Form. (Attach an additional sheet of paper if necessary). _____

3Step 6: Release, Hold Harmless, Consent, Agreements Must be signed in the presence of a NOTARY (or lawyer) by both parents and participant if participant is under the age of 18.

Medical and Travel Release, Hold Harmless Agreement: (If you are under 18, a parent/guardian must complete the following)

On behalf of myself/my child, I further authorize Youth Quests Int'l, or Hope For Youth to:

- Release any and all other medical information or records to any party deemed necessary by Youth Quests Int'l, its agents, servants, employees;
- Assign for the providing of medical treatment to my child or to members of the missionary group;
- To insure proper placement of my child in such group.

I hereby release and agree to indemnify Cross Cultural Adventures, 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 Cross Cultural Adventures harmless from any and all costs, damages or expenses incurred by Cross Cultural Adventures as a result of any claim or action filed by any party alleging damages incurred as a result of any medical treatment provided or authorization for treatment provided.

I am aware that serious illness or injury may occur on a mission trip and that such illness and injury may result in myself/my child incurring costs, expenses, and damages for which I am solely responsible including, but not limited to, return of myself/my child by air ambulance or other extraordinary means. I also understand that mission trips may be associated with risk 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 myself or Cross Cultural Adventures.

I hereby release and hold harmless Cross Cultural Adventures, 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 my/my child's participation in this trip. I understand that this release and indemnification releases liability for the conduct of Cross Cultural Adventures and its agents, servants, employees or assigns.

I also give Cross Cultural Adventures the right to use my/my child's picture, voice and/or testimony in any form of promotional or advertising materials.

Consent for Medical Treatment

- Participant wishes to be a member of a Cross Cultural Adventures missionary group which will be traveling to and staying in the country or countries identified by the Country Trip Code on the first page of this Travel Release Form. Certain circumstances may occur resulting in Participant's need for medical/dental care and treatment, and further resulting in Participant's or (in the case that Participant is a minor) Participant's Parent's or Legal Guardian's inability to personally give consent for such care and treatment. In consideration of permission from Cross Cultural Adventures for Participant to participate in said missionary group, Participant or (in the case that Participant is a minor) Participant's Parent or Legal Guardian authorizes Cross Cultural Adventures, or any designated agent of Cross Cultural Adventures or medical facility to act on Participant's behalf should Participant be unable to do so and to consent to all medical/dental care and treatment, including but not limited to diagnostic test, x-ray examination, anesthesia, surgery or other procedures which Cross Cultural Adventures deems necessary for Participant's medical well-being for the duration of the mission. This consent is given in advance of any specific diagnostic tests, treatment, surgery or medications, and is given to provide authorization and specific consent for medical/dental treatment and care on Participant's behalf. Any consent by Cross Cultural Adventures shall have the same force and effect as if Participant had personally given the consent.
- I certify I have personal health insurance, **including foreign countries, with no territorial limitation, for the providing of medical services** to participant which will provide coverage for participant during the duration of said mission. I understand that Cross Cultural Adventures provides no health insurance plan. Cross Cultural Adventures can refer you to a very good International Insurance Company.

- I understand that proof of insurance coverage will be due to my health care provider at the time of treatment or office visit. If a copy is not presented at the time of visit, health care facilities reserve the right to refuse treatment for non-urgent visits.

Accountability Agreement

The rules and regulations of Cross Cultural Adventures are specifically designed to ensure the safety and well-being of each team member and to maintain the high degree of integrity required to work effectively in a cross-cultural setting. These rules and regulations are enforced by Cross Cultural Adventures staff, which includes Head Leaders, Team Leaders and Advisors. Enforcement shall occur in a manner which **Cross Cultural Adventurs staff** feels is in accordance with these principles and the stated purpose of the project. We expect full cooperation from members and parents in disciplinary decisions made. **The discipline committee reserves the right to send home any team member that shows rebellion, or disregard for the stated rules and regulations. The team member and/or their family are responsible for any cost involved in sending the team member home. These costs may include, but are not limited to, airfare, hotel and food for the team member and chaperone. I have read the rules, regulations and the disciplinary measures and agree to abide by them.** (See the Acceptance Packet.)

Behavioral Agreement

By participating in a Cross Cultural Adventures trip, I understand I am expected to follow the stated rules as well as carry myself according to their principles. I understand the Youth Quests Oath is the standard of conduct for all Cross Cultural Adventures members and will follow it to the best of my ability. The characteristics of the Cross Cultural Adventures Oath include:

- Honor – I will be honorable through thoughts, actions and speech daily.
- Character – I commit to listen to and obey, knowing that when I do so, character and power will be made manifest in my life and in the lives of others.
- Relationships – I commit to love and esteem others higher than myself, understanding that my leaders, team members and the people of the world are to be treated with love and respect.

***** Must Read Before Notarizing *****

If participant is under 18 and both birth parents notarized signatures are not available, proper documentation must be attached. Documentation may include:

- Custody papers showing which parent or relative guardian has *sole* custody;
- Copy of parent's death certificate;
- Copy of Participants birth certificate that does not have the father's name on it;
- If the aforementioned are unattainable, please contact your GE Representative toll free at 1.866.5.GLOBEX.

My/our enclosed signature signifies my/our approval of all limitations listed above as well as my/our agreement with the *Accountability and Behavioral Agreement*. I/we have read and understand the above information. My/our signature represents that all information on these forms is true and correct to the best of my/our information.

Father's signature (if applicant under 18)	Mother's signature (if applicant under 18)	Date /___/___
Guardian's signature (if applicant under 18)	Participant's signature	Date /___/___

For Notary
**Note to notary: If you do not have a notary stamp we need other proof of notary such as a copy of notary certificate.*

State of _____, County of _____.
 Before me, the undersigned, a Notary Public in and for said county and state on _____, 200__, personally appeared the identical person who executed the within and foregoing instrument, and acknowledged to me that he/she executed the same as his/her free and voluntary act and deed, for the uses and purposes therein set forth. Given under my hand and seal of office the day and year above written.

Notary Stamp

My commission expires ___/___/___

Step 7: TRF Final Checklist

All boxes not italicized **must** be checked (parents sig. not needed when participant is 18+)

Insurance	Medical/Emergency Info	Signatures
<input type="checkbox"/> Company Name	<input type="checkbox"/> Parent and Emergency contacts	<input type="checkbox"/> Father's notarized sig.
<input type="checkbox"/> Policy #	<input type="checkbox"/> Medical Checklist	<input type="checkbox"/> Mother's notarized sig.
<input type="checkbox"/> Phone #	<input type="checkbox"/> Medical Questions	<input type="checkbox"/> Participant's notarized sig.
<input type="checkbox"/> Copy of Insurance Card	<input type="checkbox"/> MMR <input type="checkbox"/> DPT <input type="checkbox"/> Polio	<input type="checkbox"/> <i>Documentation if needed</i>
	<input type="checkbox"/> Updated Tetanus (1994+)	
	<input type="checkbox"/> <i>Doctor's Release Form if needed</i>	

Frequently Asked Questions

- Can I use immunization forms and other documents from previous trips?
No. Please update all information this year.
- Is there any additional documentation needed in the event that one parent is deceased?
Yes, please attach a copy of their death certificate.
- If my parents are divorced or separated, do I need both signatures?
If one parent has sole custody, then we only need a notarized signature from that parent as well as a copy of the legal documentation stating custody.
If the parents are separated and both parents hold legal custody, we still need notarized signatures from both parents. If one parent has never been around or is unreachable, we need legal recognition of this from a lawyer. If father did not sign the birth certificate, then a copy of that will do.
- If I know I have had all my childhood immunization dates, but don't know them, can I just write "completed"?
No, we need the actual year your immunization was administered. Tetanus must be within the last ten years.

Medical Release Form

(ONLY if you checked 'yes' to any question on this Medical Checklist, take this form to your physician to fill out the following section.)

From experience, Cross Cultural Adventures' staff has had participants who have experienced difficulty engaging in daily activities cross-cultural setting. Daily activities for most destinations may include and are not limited to: physically challenging training, high intensity aerobic activity, hiking, and extended periods of walking. Dietary and climate changes also add to the physical intensity of our trips as well as the high probability of, at some point, experiencing lack of sleep. Please be considerate of these factors as you evaluate the Participant's physical readiness for such conditions.

Physician's Name (Please Print) _____

Address _____

City _____ State _____ Zip _____

Work # (____) _____

Blood Pressure: _____ (Optional)

Age: _____ Birthday: _____ / _____ / _____

I have reviewed the Participant's **medical information and history**. I have performed a physical exam. (Please indicate the appropriate choice)

- I find the Participant to be in adequate condition for participation in the aforementioned daily activities.
- I have prescribed a medical plan of action for the Participant to meet prior to the mission trip in order to participate in the daily itinerary during the mission trip.
- I do not recommend the Participant to participate at this time.

Physician's Signature _____

Date ____ / ____ / ____