Medical Information Form

Last Name _____ First _____ MI_____

Address _____ City _____ St _____ Zip_____

Phone _____ Occupation_____

*Social Security Number _____ Date of Birth _____

Church _____ Church City, State_____

Personal Physician _____ Phone_____

*Insurance Company _____ *Phone _____

*Policy # _____ *Insured ID # _____ *Prescription Card # _____

In case of emergency contact:
Name _____ Relationship _____

Primary Phone: _____ Alternative Phone:_____

Name _____ Relationship _____

Primary Phone: _____ Alternative Phone: _____

Medication(s) you cannot take
_____

Medication you are currently taking
_____
These medications are to be administered by (circle one): Self / Staff

Allergies / special health problems or concerns
_____
Do you have a current tetanus shot? Yes / No If yes, indicate date _____
If no, we encourage you to get one before you come.

*In lieu of this information, you may provide a copy of the front and back of your medical insurance card. **Both pages must be FULLY completed and kept in the vehicle in which you are traveling at all times.**

Statement of Activities & Release Form

Mountain T.O.P. is a Christian Service ministry with the people of the Cumberland Mountains in Tennessee. Volunteers participating in the activities of this ministry will be expected to be involved in all activities and to respect the people of the Cumberland Mountains at all times.

Volunteers will participate in (but will not be limited to) home repair projects and work with local youth as need is determined and are within the capability of the volunteer service team. These activities may include the use of hand tools and the handling of materials and supplies. Power tools will only be used if the individual has the necessary skills to appropriately handle the power tool. Participants are never forced or required to engage in any work or activity in which they feel they are not able to participate safely.

Participants understand that photos and videos may be taken during the course of the camp week that may be used by Mountain T.O.P. in the future promotion of our ministries and programs.

Participants are expected to follow all guidelines of participation, philosophies, and expectations set by the organization and camp staff. Examples of unacceptable behavior include sneaking out after lights out, violating the tobacco policy, abuse or harassment, and other Mountain T.O.P. policies, going to places in the area which have been identified by camp staff as dangerous, and being disruptive to the camp life.

We acknowledge that every effort has been made in preparing the participants for this mission experience. We therefore release Mountain T.O.P., Incorporated, its agents, employees, and any and all persons connected therewith from any and all liability, claims, and causes of action of any type whatsoever arising out of or in any way connected with participation in the activities of the Mountain T.O.P., this includes releasing Mountain T.O.P. of any liability connected with COVID-19.

Further, consent/permission is given for (participant) _____to be treated by competent medical personnel in the event of an accident or medical emergency and to receive reasonable medical treatment as deemed necessary by a licensed physician.

In the event treatment is called for which a physician and/or other professional health care provider in the hospital/clinic refuses to administer without my consent, we hereby authorize:

MTOP Camp Director: _Mike Feely_
to give such consent for us in the event that we are not readily accessible by phone. If in the event it becomes necessary for either of the identified persons to give consent for us, we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from giving such consent. We understand that Mountain T.O.P. requires proof of personal insurance or acknowledgment of financial responsibility for all medical expenses. We agree that our insurance company (if applicable) will be used for all necessary medical expenses and we are aware that we may be billed by the medical provider for any medical expenses not covered by our personal insurance policy and will be responsible for payment of those expenses.

This is the _____ day of _____, 2024.

_____
Signature (Participant)