

Name _____
Trip _____

BLUE FORMS

PLEASE MAKE COPIES OF THESE FORMS AND MAIL ORIGINALS TO THE JSMI OFFICE

BEFORE MAILING YOUR BLUE FORMS, PLEASE MAKE SURE YOU HAVE COMPLETED THE FOLLOWING:

- Fill in **ALL** blank spaces provided. (If something does not apply to you please mark “Not Applicable or N/A”)
- Have page 5 notarized (This can be done at your local bank)
- If you checked “YES” to any of the boxes at the bottom of page 4: Have your primary physician complete page 6

****Please make sure ALL information is correct before sending your Blue Forms to JSMI Global Ventures.**

Name _____
Trip _____

BLUE FORMS

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*If you answer "Yes" to any of the following, please give a complete explanation below and/or on a separate sheet.
Please include date of last involvement or episode and length of involvement or episode.

Have you ever:

- | | |
|--|--|
| Been expelled from school? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Served time in a detention center or jail? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently on trial for or been convicted of a crime? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Been involved with tobacco products? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Been involved with alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Been involved with illegal drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Been involved with gang-related activities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Been involved with a cult or the occult? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had diabetes or hypoglycemia? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Taken medication for behavior? (Please list below) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had seizures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had fainting spells? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had an eating disorder? (Please list details below) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had breathing problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had psychiatric care? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Involved in homosexual activities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have any physical impairment? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Had problems entering or exiting the U.S.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Explain: _____

MINISTRY EXPERIENCE

Do you have any drama experience? YES NO

If yes, please explain: _____

Please rate your drama skills on a scale from 1-10 _____

Do you have any children's ministry experience? YES NO

If yes, please explain: _____

Have you ever been or would like to be a clown for Children's ministry? YES NO

Do you feel comfortable speaking in front of large groups? YES NO

Do you have any experience preaching? YES NO

If yes, please explain: _____

I have read and understand the above information. The information I have given J.S.M.I. – John Smithwick Ministries International is accurate and true to the best of my knowledge.

I also give J.S.M.I. the right to use my picture, voice and/or testimony in any form for promotional or advertising materials. **My enclosed signature (and signature of my parent or legal guardian if I am under the age of 18) signifies my approval of all limitations listed above.**

Signed _____

Date ____/____/____

Parent Signature _____

Date ____/____/____

(Required if applicant is under the age of 18)

THIS DOCUMENT MUST BE COMPLETED IN FULL

CONSENT FOR MEDICAL TREATMENT; RELEASE AND HOLD-HARMLESS FOR TRAVEL

1. Missionary's Name: _____ Birth date: ____/____/____
Social Security # _____ - _____ - _____
2. WHEREAS, (I, or my child) _____, wishes to be a member of a J.S.M.I. – John
(print name clearly)
Smithwick Ministries International missionary group
3. which will be traveling to and staying in _____ (country) and WHEREAS, certain
(print name clearly)
circumstances may occur resulting in (my child's, my) need for medical/dental care and treatment, and further
resulting in my inability to personally give consent for such care and treatment; THEREFORE, In consideration of
permission from J.S.M.I. for (my child, myself) to participate in said **missionary group**,
4. I, _____, being of legal age, authorize J.S.M.I., or any **designated** agent of J.S.M.I., to act
(print name clearly)
on (my child's, my) behalf should I 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
J.S.M.I. deems necessary for (my child's, my) medical well-being for the duration of the mission. This consent is
given in advance of any specific diagnosis, treatment, surgery or medications, and is given to provide
authorization and specific consent for medical/dental treatment and care in (my child's, my) behalf. Any consent
by J.S.M.I. shall have the same force and effect as if I had personally given the consent.
5. I certify I have personal health insurance, **including foreign countries, with no territorial limitation, for the
providing of medical services to (my child, me)** which will provide coverage for (my child, me) during the duration of
said mission. I understand that J.S.M.I. provides no health plan.

Company (Must provide copy of medical insurance card) Policy #

(_____) _____
Insurance Company Phone Number

I hereby release J.S.M.I., its agents, servants, employees and assigns for any and all damages, liability or costs resulting from the authorizing of medical treatment on (my child's, my) behalf under the terms of this consent. I further hold J.S.M.I. for any and all costs, damages or expenses incurred by J.S.M.I. 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 understand that this release and identification releases treatment for the conduct of J.S.M.I. and its agents, servants, employees or assigns even if such conduct is negligent.

Closest Family Contact(s)

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

In case of emergency, Second Contact:

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

CHILDHOOD IMMUNIZATIONS (These must be up-to-date, **please do not leave blank.**)

Yes	No	Type	Year Administered	Yes	No	Type	Year Administered
___	___	Mumps/Measles/Rubella	_____	___	___	Tetanus	_____
___	___	Diphtheria/Pertussis/Tetanus	_____	___	___	Other	_____
___	___	Polio	_____				

Please complete the following questions:

- Are you currently taking any prescribed medication? Yes _____ No _____
If yes, please specify the medication and the dosage: _____
- Are you currently using any non-prescription drugs on a regular basis? Yes _____ No _____
If yes, please specify: _____
- Have you ever received treatment or counseling for alcohol or chemical abuse? Yes _____ No _____
If yes, Please specify when and where: _____
- Are you presently under a physician's care for any illness? Yes _____ No _____
If yes, Please explain: _____
- What was the date of your last physical exam and who was the Physician? _____
- Are you a vegetarian? Yes _____ No _____
If yes, how long? _____. Please be aware that you may need to eat meat as part of cultural sensitivity!

Please list all surgical operations or hospitalizations you/your child have undergone.

- 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 by the above questions.

PLEASE LIST ALL KNOWN ALLERGIES:

Example: Shellfish, Peanut Butter, Bee Stings

ALL QUESTIONS MUST BE ANSWERED. ANY MISREPRESENTATION WILL VOID YOUR ACCEPTANCE.

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Chronic wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Counseling treatment
<input type="checkbox"/>	<input type="checkbox"/>	Any other respiratory problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	<input type="checkbox"/>	Cysts or Tumors of any kind	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, epilepsy or seizures
<input type="checkbox"/>	<input type="checkbox"/>	Chronic or persistent cough	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	Skin disorder other than acne	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or any other blood disorder
<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Serious bodily injury
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or Hypoglycemia (low blood sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid ailment
<input type="checkbox"/>	<input type="checkbox"/>	Circulatory trouble	<input type="checkbox"/>	<input type="checkbox"/>	Severe allergic reactions
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Any other disease, disability, or deformity not listed above
<input type="checkbox"/>	<input type="checkbox"/>	Major Hearing or Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>	AIDS virus or HIV
<input type="checkbox"/>	<input type="checkbox"/>	Intestinal or bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	Persistent, recurring indigestion, stomach or duodenal ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	High or Low Metabolism
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder stones or colic
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism, Arthritis, painful swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Severe knee problems	<input type="checkbox"/>	<input type="checkbox"/>	Breast or menstrual disorder, venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure / any cardiac problems			

****PLEASE NOTE THE FOLLOWING – IF YOU CHECKED “NO” TO ALL THE QUESTIONS ABOVE YOU ARE NOT REQUIRED TO COMPLETE THE DOCTOR’S RELEASE FORM ON THE 5th PAGE.**

IF YOU CHECKED “YES” TO ANY OF THE ABOVE QUESTIONS, YOUR ACCEPTANCE WILL BECOME VOID IF THESE STEPS ARE NOT FOLLOWED:

- 1) VISIT WITH YOUR DOCTOR
- 2) HAVE HIM / HER COMPLETE AND SIGN THE DOCTOR’S RELEASE FORM ON THE 6th PAGE.

MEDICAL RELEASE: (ALL APPLICANTS MUST COMPLETE ENTIRELY WITH NOTARIZATION. If you are under 18, a parent or guardian must complete the following for you. REMEMBER TO PRINT FULL NAME OF MISSIONARY CLEARLY IN ALL BLANKS)

I FURTHER AUTHORIZE FOR (MYSELF, MY CHILD) _____
(print name clearly)

J.S.M.I. – JOHN SMITHWICK MINISTRIES INTERNATIONAL TO:

- RELEASE ANY AND ALL OTHER MEDICAL INFORMATION OR RECORDS TO ANY PARTY DEEMED NECESSARY BY J.S.M.I., ITS AGENTS, SERVANTS, EMPLOYEES
- ASSIGN FOR THE PROVIDING OF MEDICAL TREATMENT TO _____ OR TO MEMBERS OF THE MISSIONARY GROUP (print name clearly)
- TO INSURE PROPER PLACEMENT OF _____ IN SUCH GROUP (print name clearly)

I AM AWARE THAT SERIOUS ILLNESS OR INJURY MAY OCCUR ON A MISSION TRIP AND THAT SUCH ILLNESS AND INJURY MAY RESULT IN (MY CHILD, MYSELF) OCCURRING COSTS, EXPENSES, AND DAMAGES FOR WHICH I AM SOLELY RESPONSIBLE INCLUDING, BUT NOT LIMITED TO, RETURN OF (MY CHILD, MYSELF) BY AIR AMBULANCE OR OTHER EXTRAORDINARY MEANS AT A COST OF \$10,000 OR MORE.

I HEREBY RELEASE AND HOLD HARMLESS J.S.M.I. – JOHN SMITHWICK MINISTRIES INTERNATIONAL, ITS OFFICERS, EMPLOYEES, AND REPRESENTATIVES / VOLUNTEERS FROM ALL LIABILITY FOR PERSONAL INJURY, INCLUDING DEATH, AS WELL AS ALL PROPERTY DAMAGE OR LOSS ARISING OUT OF _____'S

(print name clearly)

PARTICIPATION IN THIS TRIP. I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. THE INFORMATION I HAVE GIVEN J.S.M.I. IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

MEDIA PERMISSIONS: I ALSO GIVE JOHN SMITHWICK MINISTRIES INTERNATIONAL OR ANYONE THEY MAY APPOINT, FULL PERMISSION TO CAPTURE, RECORD AND UTILIZE, ANY VIDEO, AUDIO, PHOTOGRAPHS, OR OTHER COPIES OF MY IMAGE OR RECORDINGS OF MY VOICE, AT THEIR DISCRETION, FOR ANY PURPOSE, INCLUDING AND NOT LIMITED TO, FILM, TELEVISION & RADIO BROADCASTS, ADVERTISING, PRINTED MATERIALS, INTERNET COMMUNICATIONS ETC. I UNDERSTAND THAT I WILL NOT RECEIVE ANY PAYMENT OR COMPENSATION FOR THE RECORDING OR USE OF ANY OF THE ABOVE STATED MATERIAL.

6. X _____
Missionary's signature Date

7. X _____
Guardian's signature (if applicant under 18) Date

8a. X _____
Father's signature (if applicant under 18) Date

8b. X _____
Mother's signature (if applicant under 18) Date

***If you are in the legal custody of both parents - Required: both parents' signatures

***If you are in the legal custody of one parent - Required: the signature of the one who has legal custody and a copy of a legal document evidencing the custody arrangement, or a notarized copy of a death certificate for a deceased parent.

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.

9. State of _____, County of _____.

Before me, the undersigned, a Notary Public in and for said county and state on _____, 201__, personally appeared the identical person who executed the within and forgoing 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 on ___/___/___

DOCTOR'S RELEASE FORM

Complete this form **ONLY** if you checked 'yes' to any of the questions on the medical checklist on page 4.

In the past J.S.M.I. – John Smithwick Ministries International has had people who have experienced difficulty participating in the daily mission activities. The missionary will be involved in challenging drama training (choreography) and extended periods of walking and hiking as part of the daily itinerary. Dietary and climate changes also add to the physical intensity of our trips. Please be considerate of these factors.

Doctor's Name _____
Address _____
City _____ State _____ Zip _____
Work # (____) _____

Missionary's name _____
Address _____
City _____ State _____ Zip _____
Phone # (____) _____ Work # (____) _____

Sex: _____M _____F Weight _____ Height _____

Blood Pressure: _____ (Optional)

Social Security Number: _____ - _____ - _____

Age: _____ Birthday: _____ / _____ / _____

I have reviewed this patient's **Medical Information, Checklist Form and Medical History**, and I have performed a physical exam. *(Please indicate the appropriate choice)*

- I find him/her to be in adequate condition for international travel, participation in high-intensity activities and choreography in a third world country.
- I have prescribed a medical plan of action for him/her to meet prior to the mission trip in order to participate in the daily itinerary during the mission trip.
- I do not recommend this person to participate at this time.

X Physician's signature _____ Date ____/____/____