

Latin America Mission

short-term ministries

NOTICE: Due to HIPAA privacy laws, this form must be mailed separately from the application, directly to the VP of Personnel.

Attn: VP of Personnel, P.O. Box 52-7900, Miami, FL 33152-7900
1.800.275.8410 Fax 305.885.8649 Email: short-term@lam.org

Confidential Health Form

Name _____

Write N/A if question does not apply.

Please describe your general health: Vigorous Good Fair Poor

Height _____ Weight _____

List all medical problems for which you have received medical care in the past twelve months.

Date of your last physical _____

List any prescription drugs which you are now taking.

List any food, drug or animal allergies.

List any history of major illness, chronic ailment, physical disabilities or surgeries

Will any of these conditions require special housing or dietary considerations? Yes No Please specify:

Have you adopted a diet preference (e.g. vegetarian)? Yes No If so, please explain:

Are you willing to forego it during your service? Yes No If not please explain:

Information attained from the following questions aid placement and member care of volunteers. Affirmative answers will not necessarily exclude you from service with the Latin America Mission. Your answers will be confidential.

Have you ever struggled with:

substance abuse _____

pornography _____

sexual identity _____

extramarital sex affairs _____

violence in intimate relationships _____

severe depression _____

eating disorder _____

obsessive compulsive behavior _____

gambling addiction _____

bi-polar disorder _____

If so, please explain (**please attach separate sheet**)

Have you experienced abuse of any nature? Yes No If so, please explain (again, **please attach separate sheet**)

Have you received any professional or pastoral counseling? Yes No

If so, please describe reason, length and nature of counseling:

Does your counselor know of your desire to serve as a missionary in a cross-cultural setting? Yes No

Name of counselor: _____ Phone number: _____

May we contact your counselor for a reference? Yes No If not, please explain:

Beneficiary for the Accidental Death or Dismemberment benefit which is part of the LAM group insurance:

Name _____ Relationship _____

In case of emergency, contact:

Name: _____ Relationship: _____

Complete Address: _____

Home Phone: _____ Work Phone _____

Cellular _____

Name: _____ Relationship _____

Complete Address _____

Home Phone: _____ Work Phone _____

Waiver

In being accepted and allowed to participate in the Short-Term Program and activities associated with its program and location, I assume responsibility for my actions. I release the Latin America Mission (hereafter LAM), its trustees, employees, missionaries and agents from liability, loss, injury or damage to myself or my property. Nothing contained herein shall excuse the LAM, its trustees, employees, missionaries or agents from responsibility to act with reasonable care for the safety of myself or my property.

I hereby release the LAM, its staff, trustees, employees, missionaries, agents or sponsors of this activity from responsibility and liability for any injury or illness that I may sustain during this activity.

In the event of an emergency, I hereby authorize an adult leader of this activity (affiliated with the LAM), as an agent of me, to consent on my behalf to medical treatment. In this regard I consent to allow said adult to authorize medical, dental or surgical diagnosis; X-ray examination; treatment including surgery, and hospital care for me if needed, and if advised and supervised by a licensed physician, surgeon or dentist.

Name of Applicant: _____
(Please type or print)

Signature of Applicant: _____ Date: _____