

2023 Moving Mountains Mission to Guatemala

Thank you for your interest in the Moving Mountains Mission to Guatemala 2023. An experience on a mission trip can truly change your life and draw you closer to God and God's people. Please read the following information carefully, and complete the medical information form that follows. All applicants are required to have their personal physician's clearance to participate in this mission.

- Each applicant is required to send in a \$300 deposit to reserve a place on the mission team. This deposit becomes non-refundable once you have received your physician's clearance to participate. If your physician does not feel you are able to participate, your deposit will be refunded.
- Please complete the Medical Information form. Your medical information should be reviewed and thoroughly discussed with your primary care physician.
- Medical clearance forms must be completed and returned to the mission leadership team before June 17, 2023. Applicants who do not submit the completed forms by this deadline may forfeit their spot on the team, and their deposit will be non-refundable.
- Expense of passports, required vaccinations, medical evaluations, and medications for personal use are the responsibility of the mission participant.
- Specific questions about work crew expectations or concerns about your ability to participate fully in the mission should be directed to the Moving Mountains Mission Team leaders: (lisaklr6@gmail.com)

Mission trips can be extremely strenuous and stressful. They may include long plane and bus rides. Sometimes total travel times can reach 10 to 18 hours in duration (traveling to airport + flights + bus). Travelers are required to carry their own luggage. Restrooms are not always readily accessible. There can be a considerable amount of walking on work crew locations, in addition to the possibility of climbing hills, rugged pathways, and stairs. Some mission experiences require extended hours of demanding work with limited time to rest. Sleeping arrangements may not be comfortable and, in most instances, you will share a room with 2 to 3 other people. Air quality may be poor in some locations and water quality varies. Foods are unique to the country. Mealtimes are not always consistent and the ability to meet specific dietary needs is often restricted. Access to emergency medical care is very limited on most international mission trips.

Please complete the attached Medical Assessment Form
All information will be kept confidential by the MM Leaders and
Medical Professionals Return all completed forms to MM
by June 17, 2023

Moving Mountains Mission 2023 Medical Form

For use in Medical Emergencies & Assessment (For review by a medical professional)

Full Name: _____

Medical Insurance Provider: _____ Policy # _____

Name of your Physician: _____

Address City: _____ State: _____ Zip: _____

Office Phone: (____) _____ After hours Phone (____) _____

Please list all the drugs/medications you are taking including: strengths/dosage and time administered. _____

Please check if you have any of the following medical conditions:

| | | |
|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastrointestinal disorders | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Asthma/Breathing difficulties | <input type="checkbox"/> Seizures | <input type="checkbox"/> Mobility Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Chronic Anxiety | <input type="checkbox"/> Back/Neck Problems |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Obesity | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> History of Depression | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Migraines | |
| <input type="checkbox"/> Neurologic Problems | | |

How will these conditions impact your ability to perform on the mission? _____

Date of most recent tetanus immunization **(required)**

Date of Hepatitis A vaccine **(required)** _____

Date of Hepatitis B vaccine **(required)** _____

Dates of Covid-19 Vaccine **(recommended)** _____

Name of Covid-19 Vaccine: _____ Date of Booster (if applicable) _____

Please list all allergies that you have to drugs, foods, insects or animals and your reaction to them: _____

Do you have any special dietary needs? _____

Access to foods appropriate for your dietary restrictions may be limited. If you have gluten sensitivity or other gastrointestinal problems requiring a special diet, you will be responsible for bringing an adequate supply of nutritious foods to substitute when the foods that are available are not acceptable.

Do you have any sleep disorder, sleep apnea or severe snoring? How is this problem being treated? _____

Some of these conditions may be made worse by the altitude where you will be staying and working. It is important that you bring all necessary equipment to treat this, such as CPAP machines.

Do you have any physical or psychological conditions that could limit your ability to perform the mission projects? _____

Have you had any surgery, major health problems or hospitalizations in the past two years? If so, please explain. _____

List any physical limitations **to walking, climbing, or carrying supplies:** _____

Please list any medical conditions helpful for a physician to know should you require emergency medical attention during the trip: _____

_____ I have examined and determined that the mission applicant _____
is able to safely participate in the Moving Mountains Mission to Guatemala.

Physician's Signature Date: _____

Emergency Authorization

I give any licensed, practicing physician or hospital full authority to provide emergency medical treatment for me in the event such treatment is deemed necessary and I am not able to make such a decision. I also hereby give my permission for a licensed practicing physician to administer whatever medical treatment he/she may deem necessary for me in the event of any medical emergency affecting me.

Applicant's Signature: _____ Date: _____

Parent's Signature (for all minors) _____ Date: _____