

**LIBERTY CHRISTIAN SCHOOL  
UGANDA 2009  
CHECKLIST**

*Please go through this entire folder with this Checklist and do the following:*

- Complete LSM application*
- Apply for your Passport immediately if you have not already.*
- Have Parents read and sign Note to Parents (if under 18).*
- Consent for Medical Treatment; Release and Hold-Harmless For Travel (Note: If parents have joint custody, we must have both parents' signatures.) THIS FORM MUST BE NOTARIZED.*
- Complete the Medical Insurance Verification and apply for International Travel Insurance if necessary.*
- Fill out Medical Information and Checklist entirely.*

## **RULES FOR THE TRIP**

*If you break the following rules while on a LSM mission trip, you will be sent home:*

- No possession or use of illegal drugs, alcohol, or tobacco products.*
- No fireworks or firearms.*
- Never be outside the lodging complex alone.*
- No romantic involvement of any kind during training or on the mission field.*
- No stealing.*
- No pornography.*
- No entrance into opposite gender living quarters.*

*If you break the following rules while on a LSM mission trip, you will receive disciplinary action:*

- No profanity.*
- No fighting.*
- Group leaders must know where you are at all times.*
- A group leader must accompany you outside the housing complex at all times.*
- No secular music. Please leave it home.*
- Be on time for all meetings.*
- Be in the housing complex by curfew.*
- Don't be involved in any kind of behavior that would jeopardize the mission or be a negative witness for your team or your personal walk with God.*
- No ear or body piercing while on the trip.*
- No tattoos while on the trip.*
- No extreme hairstyles or hair coloring.*
- You must adhere to the Dress Code.*

### **DRESS CODE**

*Girls:*

- No miniskirts or short shorts.*
- No crop tops.*
- No two-piece bathing suits or immodest one-piece bathing suits.*
- Layered tank tops only. (No "spaghetti" strap tank tops.)*
- No off the shoulder shirts.*
- No tight pants or jeans.*
- No bicycle pants or shorts (unless layered with gym shorts on top).*
- No clothing that advertises alcohol, tobacco products, or secular rock bands, (when in doubt, don't bring it).*
- No nose rings, face rings, lip rings, etc. (we want to be sensitive to the different churches and cultures we will be ministering in.)*

*Guys:*

- No clothing that advertises alcohol, tobacco products, or secular rock bands (when in doubt, don't bring it).*
- No earrings, nose rings, face rings, lip rings, etc (we want to be sensitive to the different churches and cultures we will be ministering in.).*
- No bicycle pants or shorts.*
- No immodest swimsuits (no "Speedo's").*
- No "plumber pants" look.*
- No fishnet shirts.*

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

WHEREAS, (my child/I) \_\_\_\_\_, wishes to be a member of a Liberty Christian School mission trip, which will be traveling to and staying in \_\_\_\_\_ (country), and WHEREAS, certain circumstances and situations 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,

1. In consideration of permission for (my child, myself) to participate in said mission. I \_\_\_\_\_, being of legal age, authorize Liberty Christian School, or any agent of Liberty Christian School, to act in (my child's, my) behalf should I be unable to do so and to consent to reasonable medical/dental care and treatment, including but not limited to diagnostic tests, x-ray examination, anesthesia, surgery, or other procedures which may be deemed necessary for (my child's, my) medical well-being for the duration of the mission.
2. This consent is given in advance of any specific diagnosis, treatment, surgery, or hospital care required, but is given to provide authorization and specific consent for medical/dental treatment and care in (my child's, my) behalf.
3. Any consent by Liberty Christian School shall have the same force and effect as if I had personally given the consent.
4. I certify that I have personal health insurance with (Must provide **proof** of medical insurance.)

\_\_\_\_\_  
Company Policy # \_\_\_\_\_  
with no territorial limitation, including foreign countries, which will provide coverage for (my child/me) throughout the duration of said mission. If my company policy does not include international coverage including **\$25,000 emergency evacuation** coverage, I understand that no health plan is provided by Liberty Christian School and therefore have enrolled in the INTER-MEDICAL insurance plan.

5. I am aware that serious illness requiring return by air ambulance could cost more than \$10,000. I agree that I am solely responsible for any expenses that may arise from (my child's, my) return by air ambulance or other extraordinary means.
6. I hereby release and hold harmless Liberty Christian School, 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 (my child's, my) participation in this trip. (If you are under custody of both parents, we need both parents' signatures. If you are not, we need the signature of the parent who has custody. Some foreign countries require this.)

\_\_\_\_\_  
Father's signature (if applicant is under 18 years of age) Date

\_\_\_\_\_  
Mother's signature (if applicant is under 18 years of age) Date

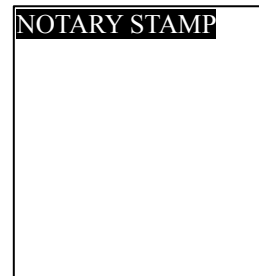
\_\_\_\_\_  
Guardian's signature (if applicant is under 18 years of age) Date

\_\_\_\_\_  
Applicant's signature Date

State of \_\_\_\_\_) ss.  
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.

My commission expires: \_\_\_\_/\_\_\_\_/\_\_\_\_ Notary Public



**MEDICAL INSURANCE VERIFICATION**

**All LSM missionaries need proof of medical coverage for involvement while in the UNITED STATES and ABROAD. Please fill out the following and mail it to RIM along with the yellow sheets from your acceptance packet.**

*If you have insurance coverage that extends to international travel, it must also include \$25,000 emergency evacuation coverage, repatriation of remains and accidental death & dismemberment.*

*If you do not have coverage that includes international travel, we recommend the enclosed plan (see form). This covers international travel for the duration of the time abroad. You can call Mary Rogers at 972.241.0440 at Goodspeed Insurance if you do not have international coverage.*

**Please provide us with the following information:**

\_\_\_\_\_ *I have full coverage, both domestic and international including \$25,000 emergency evacuation coverage, repatriation of remains and accidental death & dismemberment.*

**Company** \_\_\_\_\_ **Policy #** \_\_\_\_\_

\_\_\_\_\_ *I have domestic coverage.*

**Company** \_\_\_\_\_ **Policy #** \_\_\_\_\_

\_\_\_\_\_ *My U.S. plan does not cover international travel & emergency evacuation. I have enrolled in the enclosed insurance plan.*

**Policy #** \_\_\_\_\_

**Missionary's Name** \_\_\_\_\_ **Trip** \_\_\_\_\_

**Signed** \_\_\_\_\_

**Date** \_\_\_\_\_

*(By parent if missionary is under 18)*

**MEDICAL INFORMATION AND CHECKLIST**

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_M \_\_\_F

Address \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ Blood Pressure (optional) \_\_\_\_\_

Insurance policy name \_\_\_\_\_ Policy # \_\_\_\_\_

In case of an emergency contact:

1. Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State or Province \_\_\_\_\_

2. Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State or Province \_\_\_\_\_

**Childhood Immunizations (These must be up-to-date.)**

Yes	No	Type	Year
___	___	Mumps/ Measles/ Rubella	_____
___	___	Diphtheria/ Pertussis/ Tetanus	_____
___	___	Yellow Fever	_____
___	___	Hepatitis A	_____
___	___	Hepatitis B	_____
___	___	Malria	_____
___	___	Typhoid	_____
___	___	Rabies	_____
___	___	Other _____	_____

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

Has a doctor ever treated you for any of the following (every item must be checked)?

Yes	No	
___	___	Asthma or chronic wheezing
___	___	Emphysema or other lung and/or respiratory problems
___	___	Chronic persistent cough or shortness of breath
___	___	Tuberculosis
___	___	Any skin disorder or disease other than acne
___	___	Chronic/recurrent ear or eye problems
___	___	Impairment of hearing or vision. Meniere's Disease, cataracts or glaucoma
___	___	Persistent, recurring indigestion, stomach or duodenal ulcers
___	___	Gall bladder stones or colic
___	___	Jaundice, cirrhosis or other liver problems
___	___	Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding
___	___	Any test results indicating exposure to the AIDS virus
___	___	Albumin, blood or pus in the urine; painful or frequent urination; or kidney problems
___	___	Diabetes or hypoglycemia (low blood sugar)
___	___	Serious bodily injury
___	___	Mental health counseling or psychiatric treatment
___	___	Rheumatism, gout, arthritis or other forms of swollen painful joints
___	___	Chronic back pain, back injury or surgery; sciatica, scoliosis or other bone or joint disorder
___	___	Cysts, tumors or growths of any kind, hernia or rupture
___	___	Cancer
___	___	Fainting spells, dizziness, convulsions, epilepsy or seizure disorder
___	___	High blood pressure, heart murmurs or other cardiac problems
___	___	Vein or circulatory trouble
___	___	Severe migraine headaches
___	___	Goiter, thyroid ailment, high or low metabolism
___	___	Anemia or other blood disorder
___	___	Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders, or venereal disease
___	___	Parkinson's Disease
___	___	Severe knee injury or problems
___	___	Severe allergic reactions to either food, medicines, bee stings or any other insect bite or sting
___	___	Any other diseases, deformity, or disability not listed above

**IF YOU CHECKED "YES" TO ANY OF THE ITEMS ON THE PREVIOUS PAGE YOU ARE REQUIRED TO HAVE YOUR DOCTOR:**

1. SEE AND SIGN THIS COMPLETED FORM.
2. COMPLETELY FILL OUT THE DOCTOR'S RELEASE. IF YOU DON'T, YOUR ACCEPTANCE WILL BECOME VOID.

**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; such as antihistamines, sleeping aids? 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: \_\_\_\_\_

**Family Medical History**

Do any of your grandparents, parents, or siblings have:

Yes	No		If yes, who?
_____	_____	Diabetes	_____
_____	_____	Hypertension	_____
_____	_____	Heart Disease	_____
_____	_____	Depression	_____
_____	_____	Mental Illness	_____

What was the date and who was the attending physician of your last physical exam?

\_\_\_\_\_

List all surgical operations or hospitalizations you have undergone.

1. **Operation, illness and reason**

\_\_\_\_\_

Date \_\_\_\_\_

Name of address of hospital \_\_\_\_\_

Name of physician \_\_\_\_\_

Remaining effects \_\_\_\_\_

2. **Operation, illness and reason**

\_\_\_\_\_

Date \_\_\_\_\_

Name of address of hospital \_\_\_\_\_

Name of physician \_\_\_\_\_

Remaining effects \_\_\_\_\_

If you have been hospitalized more than two times, please explain: \_\_\_\_\_

Please provide any details pertaining to your health not covered by the above questions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

**DOCTOR'S RELEASE FORM (if necessary)**

*I have reviewed this patient's Medical Information & Checklist form and medical history, and I have performed a physical exam. I find him/her to be in suitable condition for international travel, participation in high-intensity activities (i.e., hiking several miles and conditions in a third world country.)*

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_  
Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

**DIABETICS**, at times there will be limited access to supplies for specialized diets. Sometimes the diet will be unpredictable.