NOTARIZED PARENTAL CONSENT FORM

COMPLETE THIS SECTION IF MINOR IS TRAVELING WITH JUST ONE PARENT OR NO PARENT

MEDICAL APPOINTEE PLAN

We, _____ and _____,
Father/Legal Guardian Mother/Legal Guardian
As parents and/or legal guardians of _____,
Print full name of mission project participant who is less than 18 years of age.

Appoint and designate the following two persons to be our lawful Appointees ("Appointee"), having full power to act for us, and in our name, with respect to any proposed health care services, including medication, for our child (listed above as "mission project participant."

This Medical Appointee Plan is intended to give full power to our Appointee to authorize such health care services as the Appointee deems desirable. These may include, but not be limited to, signing all documents, contracts, and agreements related to these health care services, including obligations for us to pay all expenses incurred for any such health care services. Each Appointee may exercise this power either: (1) alone and without the approval/consent of the other Appointee named below; or (2) jointly with the other Appointee named below.

Appointee #1: _____ _____
(Print Full Name) (Title/Role During Project)

Appointee #2: _____ _____
(Print Full Name) (Title/Role During Project)

Mission Project Location: _____ _____ _____
(City) (State/Province) (Country)

We give our Appointee full authority to do all acts necessary to perform the powers granted, as if we were personally present to perform these acts, and we agree with such acts.

It is understood and agreed that our Appointee shall not be held responsible or liable for any loss or losses whatsoever that may result from any acts done in good faith by our Appointee by virtue of this Medical Appointee Plan.

Any person may deal with our Appointee in full reliance of this Medical Appointee Plan. This form shall be valid for the duration of Mission Project listed above.

We understand that we can purchase insurance for our child and will include a copy of this coverage with the my child for this trip. (You can purchase this at www.missiontripinsurance.com)

IN WITNESS WHEREOF, I/we have caused this Medical Appointee Plan to be signed in my/our name(s).

Name of Father/Legal Guardian (Please Print): _____

Signature of Father/Legal Guardian: _____ Date: _____

Name of Mother/Legal Guardian (Please Print): _____

Signature of Mother/Legal Guardian: _____ Date: _____