



Children With Hope (CWH)/Tumaini Children's Center **Policies & Procedures** Missions/Work Team Trips (Up to 3 weeks)

Missions and Work Team trips will originate by notifying Children with Hope (CWH) with a request for the trip. The request can be made via email or regular mail to either info@childrenwithhope.org or Children With Hope - 627 24 1/2 Road, Suite D - Grand Junction, CO 81505.

The initial request may be brief and should include at least the following:

- Dates and length of the trip
- Number of people participating
- Purpose of the trip
- Primary contact and contact's information for the trip.

Once the initial request is made, CWH will discuss the trip as a board and with the Administrators on site to learn if there are any possible conflicts. If no date conflicts are found by the on-site Administrators, or the CWH board, then a decision will be made by the Administrators and the CWH Board regarding approval of the trip. The decision may require CWH to contact the contact person making the request to gain additional information.

The only exception for visitors not needing to go through the approval process is family members of any American staff on site. Should family members wish to visit, the American staff will simply notify the CWH Board of the dates for the family members' visit so the visit may be placed on the master calendar.

All other missions/work team visits will need to go through the approval process and adhere to the guidelines below. **If you are not going with a work team or mission trip group through CWH, then it is necessary to complete the Short Term Worker documents and application process.** Once a positive decision has been made for a missions or work team trip, the following items are necessary for the trip:

1) Each member of the team should bring at least one 50 lb bag designated for items needed by the Children's Home. The list should be determined by the Administrators on-site and confirmed by CWH. CWH will be responsible for the costs of these items, unless the team member(s) choose to donate the items. The exception to this would be if the American staff request personal items and pay for those items themselves.

2) Should the approved team have four people or less, they may stay at the Children's Home at the discretion of the Administrators. Should the team have more than four members, the team will make arrangements to stay near the Children's Home at their expense. CWH and/or the Administrators will help with this process as appropriate, but it is understood that the team members are responsible for their own expenses. These expenses include housing (if off-site) food, water and any additional Kenyan staff needed at the Children's Home to care for the visiting team. All on-site costs will be determined by the Administrators and CWH. After a team is approved, CWH will notify the team leader of the costs associated with the trip.

3) All team members must complete the appropriate CWH/Tumaini Children's Center - Application and Medical Waiver Release & Permission to Treat.

4) All team members must have the appropriate insurance, shots and passports for the duration of the trip from when the trip leaves the US until the return. This information may be scanned and emailed or copies may be sent to CWH at the above mailing address.

5) All team members must agree that they are under the supervision and authority of the Administrators while in-country.

6) Team members must be at least 18 years of age. Exceptions may be made if parent accompanies the child on the trip and the parent receives written approval by CWH.

7) Should a conflict occur in scheduling of visits/teams the following will be the priority order:

- | | |
|---|---|
| 1) American staff family members | 3) Other work team visits |
| 2) CWH board visits &/or CWH board led work teams | 4) Any other person(s) or groups wishing to visit |

**Children With Hope/Tumaini Children's Center reserves the right to update &/or change these Policies & Procedures, Application and Medical Waiver & Permission to Treat documents at any time without notice.*



Children With Hope (CWH)/Tumaini Children's Center

Application

Missions/Work Team Trips (Up to 3 weeks)

| | |
|------------------------|-----------------------|
| Name: | Phone: |
| | |
| Address: | Email: |
| | |
| City/State/Zip: | Date of Birth: |
| | |

**You may use a separate sheet of paper if you wish.*

1) Why would you like to go to Kenya to work with CWH/Tumaini Children's Center?

2) Are you comfortable with being under the authority of the American Administrator's at the Children's Home while in Kenya?

3) Have you ever traveled to a third-world country before? If so, please describe that experience:

4) Have you ever been convicted or pled guilty to, a felony or misdemeanor?

Yes No

If so, please explain:

5) Please describe your thoughts and feelings about being around multiple children:

6) Any comments or questions?

My signature below indicates that all of the above statements are accurate and truthful. Further, if accepted for this trip I commit to abide by all rules set forth by CWH/Tumaini Children's Center and I understand that I will be under the authority of the Tumaini Children's Center Administrators during my time in Kenya. Further, I have read and agree to abide by all terms outlined on the Policies & Procedures document as my signature below indicates.

Signature

Date



Children With Hope (CWH)/Tumaini Children's Center

Medical Waiver Release & Permission to Treat

Missions/Work Team Trips (Up to 3 weeks)

| | |
|---|-------------------------|
| Full Name as it appears on Passport: | Passport number: |
| | |
| Address: | Phone: |
| | |
| City/State/Zip: | Date of Birth: |
| | |

Emergency Contact:

| | |
|----------------------|------------------------|
| Contact name: | Daytime Number: |
| | |
| Relationship: | Evening Number: |
| | |

Insurance Information:

I understand that my personal health insurance will provide primary coverage for any accident, incident or event that occurs while I am a trip participant. I further understand that Children With Hope strongly encourages an international travel health insurance policy which provides secondary coverage to my health insurance.

| | |
|--|--|
| My Insurance Company: | Policy Number: |
| | |
| Whose name is the policy under? | Telephone Number |
| | |
| Insurance Company Address: | Insurance ID Number: |
| | |
| | <input type="checkbox"/> I am not currently insured. |



Children With Hope (CWH)/Tumaini Children's Center

Medical Waiver Release & Permission to Treat

Missions/Work Team Trips (Up to 3 weeks)

Medical Information:

| | |
|---|--|
| Pre-existing or present medical condition: | |
| | |
| Name & dosage of any medications that must be taken: | |
| | |
| Insurance Company Address: | Insurance ID Number: |
| | |
| | <input type="checkbox"/> I am not currently insured. |
| Date of last Tetanus Shot* | Do you wear contact lenses? |
| | <input type="checkbox"/> YES <input type="checkbox"/> NO |

*It is strongly recommended that you contact your physician to inquire about any pre-travel vaccinations he/she might suggest. It is the policy of Children With Hope to leave such decisions to the traveler and his/her chosen medical professional. Contact your County Health Department for vaccination requirements. For the Mesa County Health Dept contact Judith at 970.248.6919.

| | |
|---|---|
| Any known allergies? | Allergies to medications? |
| | |
| <input type="checkbox"/> Hay Fever <input type="checkbox"/> Insect Sting <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Condition <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Frequent Stomach Upset <input type="checkbox"/> Diabetes <input type="checkbox"/> Nervous Disorder <input type="checkbox"/> Physical Handicap |
| Please give details (include normal treatment of allergic reactions): | Should you require medical attention, please note here any information that the physicians should be aware of prior to your treatment: |
| | |
| Any activity restrictions? | I understand and acknowledge that I am in good physical and mental health and am able to walk unassisted and lift a minimum of 50 pounds without assistance. |
| | <input type="checkbox"/> YES <input type="checkbox"/> NO |



Children With Hope (CWH)/Tumaini Children's Center

Medical Waiver Release & Permission to Treat

Missions/Work Team Trips (Up to 3 weeks)

HIPAA Acknowledgement

For purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules, all health care providers shall treat my acting health care agent as my Personal Representative. As required by 45 CFR 164.524, I hereby expressly authorize any physician, hospital and any other person or organization to release and disclose to my Personal Representative any information any of them may have concerning any treatment, diagnosis, recommendation, or other facts which they may have concerning my physical condition and any health care, counsel, treatment or assistance provided to me. My Personal Representative may authorize disclosure of my protected health information to others. Health care providers covered by HIPAA include, but are not limited to, any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, insurance company and health care clearing houses.

Initials

Designation of Agent

I designate Children With Hope (CWH)/Tumaini Children's Center, acting by any of its authorized officers, board members or agents, as my agent for the purpose of consenting to, refusing, or terminating medical treatment on my behalf and to contract for payment for medical treatment on my behalf. This designation shall be effective from the time I leave the U.S. and shall not be affected by my disability; this designation shall terminate upon my return to the U.S.

Authorization for Medical Treatment

This health history is correct to the best of my knowledge and I am able to engage in all activities involved with this trip except as noted. Activities include but are not limited to building/construction, travel, recreation, childcare, etc. I hereby give permission and authorize the physician(s) selected by my Agent to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed by me.

I further authorize the physician(s) or dentist(s) to associate any necessary medical providers at his/her discretion. I understand that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage my Agent and said physician(s) or dentist(s) to exercise their best judgment regarding the requirements of such diagnosis or medical, dental or surgical treatment.

I agree to remain fully liable and responsible for the payment of any such hospital, physician, ambulance, dental or medical expenses. I further agree that by acting under this permission, authorization, designation and consent, Children With Hope(CWH)/Tumaini Children's Center does not assume any responsibility or liability for the payment of such hospital, physician, ambulance, dental or other medical expenses which may be incurred.



Children With Hope (CWH)/Tumaini Children's Center

Medical Waiver Release & Permission to Treat

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The undersigned warrants that he/she has fully read and understands this **Medical Waiver Release & Permission to Treat** agreement and voluntarily signs the same, and that no oral representations, statements, or inducements apart from the foregoing written agreement have been made to the undersigned.

Printed name of Participant

Signature of Participant

Date

Parent of Minor:

I, _____, the parent of _____, delegate to Children With Hope (CWH)/Tumaini Children's Center (or named person) as my agent for the purpose of consenting to, refusing, or terminating medical treatment for my child and to contract for payment for medical treatment on my child's behalf. This delegation and agency shall be effective _____ and continue until _____ (not more than twelve months later); this delegation and agency shall not be affected by my disability.

Signature of Parent if Participant is a minor:

This Section For Notary Use Only.....

IN WITNESS WHEREOF, I have executed this document this _____ day of _____, 20____

STATE of _____

COUNTY of _____

On this day, personally appeared before me _____, to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein mentioned.

IN WITNESS THEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____, the day and year first above written.



Notary Seal

Notary Public

My commission expires