



Short-Term Missions Application

TODAY'S DATE: _____

PERSONAL INFORMATION

Print: Full Legal Name: (as it appears on passport)

Last _____ First _____ Middle _____

Date of Birth _____ Age _____ Gender _____

Address: _____
Street City State Zip

Cell # _____ E-mail Address: _____

Occupation: _____

Martial Status: ___ Married ___ Single Date of Birth: _____

Passport Number: _____ Country of Citizenship: _____

Place and date of issue: _____

Expiration Date _____

List previous citizenships, if any _____

Place of Birth: _____
City State

All Applicants must be submitted to a background check:

Social Security Number: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Phone Numbers: _____ Email Address: _____

SERVICE/MISSIONS INTEREST

Which mission trip(s) are you interested in participating in? Explain why you feel motivated to go on this trip:

List your skills, gifts and abilities:

List previous overseas experience (country, length of stay and purpose of trip):

What is the maximum number of days you can serve (including weekends)? _____

In the last year have you used tobacco, alcoholic beverages or drugs? YES NO
Circle one

If yes, please explain how recently, how frequently, and in what quantities.

Would you be willing and able to give a devotional or speak? YES NO
Circle one

List any medical, First Aid or CPR Training & Dates: _____

Foreign language(s) I speak: _____ Proficiency: Good Fair

MEDICAL HEALTH HISTORY

Insurance Company: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Group/Policy # _____ Plan ID# _____

Please attach a copy of BOTH sides of your insurance card to your completed application

I understand it is my responsibility to check with my physician concerning immunizations. YES NO

Circle one

Please attach a copy of BOTH sides of your insurance card to your completed application

I understand it is my responsibility to check with my health insurance provider regarding out-of-country coverage. YES NO

Circle one

Name: _____ Date of Birth (dd/mm/yy): _____

Height: _____ Weight: _____ Blood type: _____ Today's Date: _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

IN THE PAST TWO YEARS HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?

Yes No

- ___ ___ 1. Rheumatic fever
- ___ ___ 2. Heart trouble, Heart attack, Angina
- ___ ___ 3. High blood pressure
- ___ ___ 4. Chest pain
- ___ ___ 5. High Cholesterol
- ___ ___ 6. Lung or breathing problems
- ___ ___ 7. Asthma
- ___ ___ 8. Hives or Eczema
- ___ ___ 9. Allergies (foods, animals, medicine, pollens)
- ___ ___ 10. Fainting spells
- ___ ___ 11. Seizures
- ___ ___ 12. Liver disease
- ___ ___ 13. Thyroid problems
- ___ ___ 14. Arthritis or Autoimmune disorder

Yes No

- ___ ___ 15. Joint replacement
- ___ ___ 16. Ulcers
- ___ ___ 17. Kidney problems
- ___ ___ 18. Kidney/other organ transplant
- ___ ___ 19. Tuberculosis (TB)
- ___ ___ 20. Anxiety or Depression
- ___ ___ 21. Chronic Fatigue
- ___ ___ 22. Are you pregnant?

MEDICAL HEALTH HISTORY

Do you have any other disease, condition or problem you think we should know about?

Do you have any health problems or physical limitations that might hinder your work in a different climate, high altitude or adverse living conditions?

If you answered yes to any of the above questions, please give a brief explanation below.

MISSION MEDICAL UPDATE SHORT TERM MISSION COUNTRY: HAITI

Dates: Departure: _____ Return: _____

Name: _____ DOB: _____ Age: _____

Phone #: _____ Ht.: _____ Wt: _____

Emergency Contact: _____ ER Phone #: _____

Physicians Name: _____ Phy. Phone #: _____

Pharmacy: _____ Phar. Phone #: _____

Blood type: _____

Allergies: _____

Medicine: _____

Food: _____

Medications: _____

***Are you being treated for a Chronic Illness/Injury? (Please Circle) Yes: _____ No: _____

If yes, a Physician Statement to travel and participate on a Short Term Mission Trip is required and should include diagnoses and treatment. (Attach Physician's signed statement) Date received: _____

LIST ALL MEDICATIONS TAKEN: (dosage and time of administration on back of this page)

RELEASE AND ASSUMPTION OF RISK FORM

MISSION TRIP: _____ DATE OF TRIP: _____

NAME: _____

ADDRESS: _____

HOME PHONE: _____

ALT. PHONE: _____

EMERGENCY CONTACT: _____

ADDRESS: _____

HOME PHONE: _____

ALT. PHONE: _____

Please list any allergies, physical disabilities or medical information we should know about:

Please list any medications that you will be taking:

Please list any dietary restrictions:

RELEASE AND ASSUMPTION OF RISK

1. I acknowledge that I have voluntarily applied for enrollment in the above listed short term mission trip and in consideration of being permitted to participate in such trip, do voluntarily execute this "Release and Assumption of Risk" on behalf of myself, my heirs and next of kin, my personal representative and my estate.

2. I acknowledge that I have been fully informed of the nature, scope and demands of the trip, and that I have met all of the prerequisites required for participation in this trip.

3. Many churches sponsor short-term mission trips. These trips usually involve a number of risks that may not be covered by insurance. The form below is for use by members and/or volunteers of the church who participate on a trip that involves travel inside and outside of the United States. It is quite likely that the church will not have insurance to cover injuries or accidents that occur on such trips, and typically, the church has no means of adequately supervising all activities involved on the trip. As a result, a church may ask members/volunteers who participate on such trips to assume all risks associated with them as a condition of their participation. In such cases, a form similar to this one is often used.

4. I am aware of the hazards and risks to my person and property associated with serving in a mission's capacity, such hazards and risks including, but not being limited to, death or injury by accident, disease, war, terrorist acts, weather conditions, inadequate medical services and supplies, criminal activity, and random acts of violence. I accept my assignment with full awareness of these risks, and, subject to any insurance coverage's that may be available to me from any source, and only with respect to my church and its agents, officers, directors, and employees, I voluntarily assume all risks of death, injury, and illness associated with such risks, and any damage to my personal property, and I release my said church and its agents, officers, directors, and employees from any liability whatsoever arising as a result of death, injury, or illness that I may suffer as a result of participation in the missions trip. I further recognize that such risks have always been associated with missionary service. 2 Corinthians 11:23-28.

5. I understand that every care and attention will be given to the health and comfort of the members/volunteers, but the church or its staff cannot be held liable for any injuries sustained which were not directly caused by their failure to take due care.

6. I hereby authorize the leader of the trip to secure such medical advice and services as may be deemed necessary for the health and safety of myself (or my son/daughter/ward) and I agree to accept financial responsibility, including in excess of the benefits allowed by

provincial health insurance plans:

a. Where the health and well being of the applicant is involved.

b. Where all attempts to contact the parent or guardian have failed or where due to the nature of the emergency there was insufficient time to contact such parent or guardian.

It shall be at the discretion of the leader of the church as to what action must be taken for the welfare and safety of the member/volunteer.

7. I accept and assume full responsibility for all harm and injury, of every nature, including death, which may occur to me or which I may suffer, and for all damages or loss to any personal property or property issued to me by New Life Church, while I am participating in the trip and, in furtherance thereof, I agree to indemnify and hold harmless New Life Church and its employees, from and against any and all claims, demands, actions or causes of action, on account of damage to personal property, or to my personal injury, or death, which may occur or result directly or indirectly from my participation in the activity, and which results from causes beyond the control of and without the fault or negligence of New Life Church and its employees.

8. I agree to abide by the rules and regulations imposed on participants by the agency and its staff.

9. I agree that I will be cooperative and helpful to and with all other participants in the trip and will not be disruptive of the objectives established for the trip or as may be designated by the staff or group consensus.

10. I declare that I am in good physical health and believe that I am able without reservation or limiting conditions to physically withstand and cope with the indicated activities of this trip.

11. I request that this "Release and Assumption of Risk" be construed and interpreted pursuant to the laws of the State of Connecticut, and if any portion thereof is held invalid, I request that the remainder continue in full force and effect.

Date

Date

Signature

Signature of Parent/Guardian (if under 18)

Street Address

Street Address of Parent/Guardian

City, State, Zip

City, State, Zip of Parent/Guardian

IMPORTANT: Please have 2 witnesses observe your signature, and have them sign below. They must be at least 18, and should not be relatives.

Witness

Witness

Address

Address

City, State & Zip

City, State & Zip

PARTICIPANT AGREEMENT

I understand that if I am able to participate in this trip, I will be required to attend any and all functions pertaining to the mission's trip. I also understand that if I am absent from any of the functions relevant to the missions trip and have not been excused by the leaders, I may be asked to forfeit my ability to participate and will not receive a refund for registration costs.

I further understand some tools and supplies may be required at the site, and I may be responsible for bringing some or all of the required items.

By signing below, I promise to attend any and all functions pertaining to the missions trip, and I will take care of all costs of the trip related to my attendance. I agree to all that is required of me, and I understand that my registration money is non-refundable.

(Printed name of participant)

(Signed name of participant)

The following contractual area needs to be completed if the minor is traveling without parental supervision.

PARENTAL PARTICIPANT AGREEMENT FOR MINOR

I have read through the information and understand that my son/daughter will be attending a mission's trip, if able. I am aware of the type of activities that will take place during the week of the mission's trip. I understand what is required of my son/daughter in relation to attending any functions that pertain to the trip. I give permission for my son/daughter to be considered for the trip. I furthermore understand that all raised monies and any monies over the needed amount cannot be refunded, they are non-transferrable, nor can they be carried over to the following year.

(Printed name of parent or guardian)

(Signed name of parent or guardian)

CONSENT FOR TREATMENT OF A MINOR

This form MUST be completed and notarized for the participant's application to be processed. Notary Publics are on staff at Parkview, but you must make an appointment with them to have it signed and stamped. Notary Publics are also on staff at your local bank, law office, and courthouse.

To be completed by Parents / Guardians:

I, _____,

(Printed name of parent / guardian)

being the parent or legal guardian of

(Printed name of participant)

give my consent for emergency medical and surgical treatment of this minor in the event that such treatment becomes necessary. I grant my permission for treatment in a licensed hospital by a licensed physician and the physician's assistants and designees, including such hospital personnel as the physician may deem necessary. I understand that hospital personnel will make reasonable attempts to contact me before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this consent form may receive all treatment provided according to generally accepted standards of medical practice with the following limitations (if none, write "NONE"): _____

My consent is effective for the following time period: _____

(Printed name of parent / guardian) (Signed name of parent / guardian)

(Date)

To be completed by a Notary Public:

County of: _____ State of: _____ Country of: _____

On this, the _____ day of _____, 20_____, before me, the undersigned Notary Public,
(Date) (Month) (Year)

personally appeared the above named individuals for the purposes therein contained.

In witness whereof, I hereunto set my hand and official seal.

(Notary Public Signature) (Commission Expiration Date)