



MISSION SERVICE APPLICATION

Full Name: _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip _____

Phones: Home _____ Cell _____

Email: _____ Sex: M F Age _____ D.O.B. _____

Team Captain's Name: _____ Travel Dates: _____

Passport Number: _____ Issuing Country _____ Place Issued _____

Date Issued _____ Date Expires: _____

Name exactly as appears on passport _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____

Day Number _____ Night _____ Cell _____

Have you been on a mission trip before? Y N

Where? _____

Church you attend _____

Church phone _____ Pastor's Name _____

Church Address _____

What do you plan to do while visiting us? _____

The information I have supplied in this application is true.

Signature _____ Date _____



MINOR'S TRAVEL PERMISSION FORM

Permission Form for a minor to leave the United States when both parents are not traveling with the minor.

_____, a minor of less than 18 years of age,
(print name of minor here)

Has the permission of both parents/legal guardians to leave the United States from the span of the dates of

_____ to _____
(date of departure) *(date of return to US)*

To participate on a Heart of Christ short-term foreign mission trip to the country of Honduras.

Traveling with my child will be _____
(Name of Team Leader)

(Printed name parent/legal guardian #1)

(Printed name parent/legal guardian #2)

(Signed name parent/legal guardian #1)

(Signed name parent/legal guardian #2)

(Date signed parent/legal guardian #1)

(Date signed parent/legal guardian #2)

___ Check if only one parent is signing and has sole custody or if the other parent is deceased.

Signature Team Leader _____ Date _____

(Notary Public)



MEDICAL HISTORY and EMERGENCY TREATMENT RELEASE FORM

Name _____ D.O.B. _____

Height _____ Weight _____ If pregnant, stage of pregnancy _____

Blood Type _____ Date of last Tetanus Booster _____

Drug Allergies _____

Food Allergies _____

Pertinent Medical History: _____

Current Health Problems:

List of current medications (Name and Dosage)

Physician's Name _____ Phone _____

Address of Physician _____

Emergency Contact _____ Phone _____

I authorize the personnel of Heart of Christ and/or any medical personnel on my team to obtain and administer emergency medical treatment for me should I become ill or incapacitated while on this mission trip. I also authorize the personnel of Heart of Christ and/or any medical personnel on my team to obtain and administer emergency medical treatment for any child of mine on this trip should I become incapacitated or am unable to be contacted.

Date: _____ Signature: _____

(If team member is a minor, the parent/guardian may sign for him/her, putting in parenthesis your relationship to the minor above the signature.)

