Application for Short – Term Ministry Team

Streams of Water Ministry

(Note: This form is CONFIDENTIAL and will be used only to determine suitability for the team.)

General Information

Birth date:________________ Male________ Female________
Passport Name:____
Passport Number:______________________________ Expiration Date: _________
E-mail: (PRINT CLEARLY) ____
Home Address: ____
City: ____
State: ____
Home phone: (___)____-_______ Cell phone: (___)____-____________________
Marital Status: Married Single
US Citizen: Yes No

Emergency Contact Information

Name:____
Relationship:____
Home phone: (___)____-___________ Cell phone: (___)____-________________

Health Information

Are you currently under the care of a physician for any condition: Yes___ No___
If so, please list.

____
____
____

Please list any illnesses, other than those listed above, for which you have seen a physician or other health care provider in the last year.

Illness	Date	Treatment

Please list all current medications, dosages and reason for taking. Include those medications taken on a regular basis as well as those taken for occasional illnesses such as migraines, indigestion, ect.

Medications	Dosage	Treatment for?

Are you allergic to any medications? If so please list.

____

____

Do you have any allergies other than to medications (i.e., Foods, environmental, ect.)?

____

____

List all the surgical operations or hospitalizations you have undergone and dates:

Surgical operations or hospitalizations Date Reasons

__________________________________ __________ ________________

__________________________________ __________ ________________

Are you currently under the care of a mental health provider for any of the above conditions? Yes____ No____ / If so which one?

____

Date of last Tetanus shot (w/in last 10 years): _________________________

Please provide information of your current family physician.

Name of physician: _________________________

Address:_________________________

____

____

____

Telephone: (___)____-________

<u>Medical Insurance Information</u>

Name of medical insurance carrier:

____

Office/Agent: _____________________

Policy/Group Number/Certificate Number:

____

Phone: ____

<u>Release and Consent</u>

Name (please print clearly): ____

Streams of Water Ministry has organized this ministry trip. I have been accepted for participation as a participant of this trip. Subject to each of the following provisions, I hereby consent to participate on this trip. This encompasses every activity which shall occur from my arrival at the designated location for the trip to the time of departure from the location of the trip. I understand that Streams of Water Ministry would not admit me on the trip in the absence of execution of this General Release.

<u>Release of Liability</u> I understand and appreciate fully the risks inherent on this trip and in travel. I fully understand the risks in participation on the trip. I am capable of participating on this trip and will do so in a safe and responsible

manner. I will comply with all safety guidelines established by Streams of Water Ministry. I fully and forever release, discharge and acquit Streams of Water Ministry and their directors and employees from any and all rights, claims, actions, demands, costs and expenses that I may have or have a right to assert, arising out of or in connection with the trip, including but not limited to damages for death or personal injuries to myself. Without intending to limit the generality of the foregoing waiver, I expressly waive any claim against the Released Persons for any personal injury or property damage which I may sustain as a result of any activity during the trip.

Consent for Medical Treatment I authorize the Streams of Water Ministry leadership to provide 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 well-being during the duration of the trip. I agree that I am solely responsible to pay for any expenses that may arise from such medical care. This Release and Consent shall remain in full force and effect until the end of the trip.

Signature: ______________________________ Date: ____________________