



CHRISTIAN WORLD
OUTREACH, INC.

Short-Term Mission Trip Application

Trip to: _____

Trip Dates: _____

The purpose of this application and the information obtained through it is to give team leaders pertinent information to insure you have a good experience during your short-term mission trip. This information will be used solely for the purpose of Christian World Outreach to do background checks and insure the best medical attention if necessary for you or your child. Christian World Outreach assumes no liability or duty as a result of receiving this information.

Personal Information:

Name: _____
(As it appears on your passport.)
Last First Middle

Address: _____
Street Apt #
City State Zip

Telephone #'s: _____
Home Cell

E-mail Address: _____

Social Security #: _____ - _____ - _____ Drivers License # _____

Maiden or previous name used: _____

Passport Information: _____
Passport Number Country of Issue Nationality
_____/_____/_____/_____
Date Issued Expiration Date Birth Date Gender

Emergency Contact: _____
Name Relationship to you

Home Telephone # _____ Cell Telephone # _____

Address _____

E-mail Address _____ Fax Telephone # _____

Addition Emergency Contact Person _____ Telephone # _____

_____/_____/_____
Initials Date



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Name of Trip Participant 18 years old or younger

*******Complete this page if 18 years old or younger.*******

My child, _____ has my permission to participate in the Christian World Outreach mission trip to _____ during the following dates, _____.

I give Christian World Outreach and its representative(s) with my child on this trip authority to request and authorize medical and/or hospital treatment for my child's benefit in the event of any injury or sickness sustained by him/her while on such trip, including, without limitation, while traveling to and from any foreign country. I agree to pay for all such treatment and to reimburse Christian World Outreach for all costs and expenses incurred by it with respect to such treatment.

I give my permission to the physician listed on the health portion of this application to secure proper treatment for my child if I cannot be contacted in an emergency.

Parent / Guardian Information:

(Both parents / guardians must complete this portion of the application.)

Father's / Guardian's Name

Father's / Guardian's Address

Home Telephone #

Cell Telephone #

Signature

_____/_____/_____
Date

Mother's / Guardian's Name

Mother's / Guardian's Address if different than above.

Home Telephone #

Cell Telephone #

Signature

_____/_____/_____
Date



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Name of Trip Participant

Personal Background: (use a separate sheet of paper to answer the following questions)

Attach a recent photograph to this application. This will be used to identify team members when meeting for the first time.

I would like to room with _____ if possible during this trip.
(All parties need to list each other's names)

What contact have you had with racial, ethnic, or cultural groups other than your own?

Do you speak any languages other than English? If so, what degree of fluency?

Have you traveled outside the United States? Where?

What previous mission projects have you participated in?

Select below any skills / talents you may have that you could share with the team and those at the teams destination. Give details about any of these skills / talents you have choosen.

Accounting	Construction	Public Speaking
Administration	Leading Worship	Teaching
Children's Ministry	Medical	Videography
Computers	Missions Mobilization	Youth Ministry
Other _____		

Have you ever been convicted of a criminal offense? If yes, give details.

Have you ever been subject to an investigation, disciplinary action or discharge by an employer, church or religious organization, licensing agency, volunteer or other organization with which you have been affiliated? If yes, please describe.

What is your involvement with your local church? What activities do you participate in?

Why do you wish to go on this mission opportunity?

How do you plan to use your experiences when you return home?

Describe your relationship with Jesus Christ.

Initials

____/____/____
Date



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Name of Trip Participant

Health Status Information:

Blood Type _____

Do you have any food, drug, or contact **allergies** including penicillin, sulfa, iodine, aspirin, Tylenol (acetaminophen) or other drugs; poison ivy, soaps, or other contact substances; milk or other food products? List them below.

Allergy:

Treatment Required:

Do you have any **dietary restrictions**? _____ If yes, please explain. _____

Have you had **major surgery** in the past 12 months? _____ If yes, please list them. _____

Do you/your child currently take any **medications**?

Diagnosis:

Medication:

Dosage:

How Often:

Date of latest **tetanus vaccination**: _____

Have you/your child been subject to: (please check if "yes")

___ asthma

___ bleeding disorder

___ fainting spells

___ convulsions

___ diabetes

___ heart trouble

___ Other (please specify) _____

Do you/your child have difficulty with: (please check if "yes")

___ eyes

___ lungs

___ nose

___ sleepwalking

___ ears

___ digestion

___ throat

___ Other (please specify) _____

Physician _____ Telephone _____

Address _____

Insurance Carrier _____ Policy # _____

Does your medical insurance cover you outside the United States? no yes

Have you confirmed this? no yes

Initials Date ____/____/____

