# CONCORD BAPTIST ASSOCIATION MISSION BUILDERS' TEAM APPLICATION AND MEDICAL RELEASE FORM

Concord Baptist Association
804 Fairmount Blvd.
Jefferson City, MO 65101

Date of Mission Trip: _____
Location: _____
Deadline to Register: _____
Amount Received: _____

**PERSONAL INFORMATION:**

Name (Last, First, Middle) _____

Address: _____ City: _____ State: ____ Zip: ____

Phone: (H) _____ (C) _____ (W) _____

Date of Birth: _____ E-mail: _____

Spouse's Name & Phone #: _____ (C) _____ (W) _____

Home Church & Association: _____

Pastor's Name & Phone #: _____

Names of additional family members going on this trip (include age for children & youth):

_____ _____

_____ _____

**All children and youth must have a parent or other adult on the team who is directly responsible for them! A completed registration form and medical release must be turned in for each participant!! Child care is available if requested in advance.**

| **Work Team Choices** | **Housing Choices** | **Other Items or Comments** |
|---|---|---|
| ____Construction | ____ Stay in a home | _____ |
| ____Kitchen | ____ Stay in a hotel | _____ |
| ____Ministry | ____ Stay in personal RV | _____ |
| ____Child Care | ____ Stay in church | _____ |

**T-Shirts** – Mark size needed: ☐ Small ☐ Medium ☐ Large ☐ XL ☐ XXL

**T-Shirts Cost** -- $8.00 no pocket (It is recommended that all team members purchase a t-shirt.)

**Cost for meals & group insurance** -- $40.00 per person (age 12 & up).

**Registration Deadline to order T-shirts is June 15. Check must accompany form.**

List Your Skills, Talents, & Experience: _____

_____

_____

_____

**EMERGENCY CONTACT, RELATIONSHIP, & PHONE:**

1. _____ _____ _____
2. _____ _____ _____

Physician's Name, Address, & Phone # : _____

_____

_____

Medical Insurance (Include name of company, phone #, address, and policy and/or ID #:

_____

_____

_____

**MEDICAL HISTORY:** **Date of Last Tetanus Shot:** _____

- ☐ Allergies--Food, Meds, Plants, Insects, etc. (explain reaction)
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Pressure (high/low)
- ☐ Blood Disorder (explain)
- ☐ Broken Bone (explain)
- ☐ Cancer (explain)
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Headaches
- ☐ Heart Disease (explain)
- ☐ Hepatitis A/B/C
- ☐ Kidney Disease
- ☐ Mononucleosis
- ☐ Past Surgeries (explain)
- ☐ Seizures
- ☐ Stroke
- ☐ Other

(Please explain the above health problems as requested as well as any other conditions of which the Team Coordinator should be aware. (May use separate sheet.)

_____

_____

_____

_____

**MEDICATIONS:** Please list medications taken on a regular basis. Include dosage & time taken.

_____

_____

_____

_____

**FOOD RESTRICTIONS (Allergies, diabetic, gluten free, etc.)**

_____

_____

_____

**THE FOLLOWING STATEMENT MUST BE SIGNED BY THE VOLUNTEER:**

The above information is accurate to the best of my knowledge. I understand this form will be kept by the Team Coordinator or the Director of Missions for use if needed. I give permission to release information to medical personnel if necessary. Should I be unconscious, I give permission to the Team Coordinator or Director of Missions to act as spokesman in granting permission for emergency treatment (including anesthesia) if necessary.

**Signature** _____ **Date**_____