

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 (must be age 12+ to work). 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

____ Construction
____ Kitchen
____ Ministry
____ Child Care

Housing Choices

____ Commute
____ Stay in a hotel
____ Stay in personal RV
____ Stay in church

Other Items or Comments

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: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies--Food, Meds,
Plants, Insects, etc.
(explain reaction) | <input type="checkbox"/> Blood Disorder (explain) | <input type="checkbox"/> Hepatitis A/B/C |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Broken Bone (explain) | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Cancer (explain) | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Blood Pressure
(high/low) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Past Surgeries (explain) |
| | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Seizures |
| | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Heart Disease (explain) | <input type="checkbox"/> 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 _____