Project 52

Mission Team Application

Name (exactly as on passport):

____

(Last name) (First name) (Middle name)

Country issuing passport: _________________Passport#________________ Expire__________

First Name (as you would like it on nametag): _____________________________________

Date of Birth: ______/_______/________ (mo/day/yr) Sex: ___Male ___Female

How many foreign mission trips have you participated in, including this one: _________

Overall Health: ___Excellent ___Good ___Fair Spanish: ___None ___A little ___Fluent

Occupation: _______________________________ (If retired, what was your occupation?)

Address: ____

City: _______________________________ State: _________________ Zip: ____________

Primary Contact Phone: ____

Secondary Contact Phone: ______________________________________

Your Email: ____

Emergency Contact Name:____

Primary Phone (_____) ______________ Secondary Phone (_____)______________

Church Affiliation/Home Church____

Why are you going on this mission trip?____

____

____

SKILLS & PREFERENCES: (Please circle all that interest you)

Cement Work	Singing	Musical Instrument(s)_____________	Sharing Testimony
Brick Work	Song Leader	Drama/Acting	Children's Ministry
Plumbing	Worship Leader	Puppets	Women's Ministry
Electrical	Teaching/Preaching	Arts & Crafts	Men's Ministry
Painting	Devotional Leader	Team Photographer	General Labor

T-Shirt Size: ___S ___M ___L ___XL ___2XL ___3XL

Project 52 Emergency Medical Information

Name: ____

(Last) (First) (Middle)

Gender: □ M □ F **Age**: __________ **Birth Date:** ____

Parent's Name (if under 21): ____

Parent's Primary Phone: (_____) ________________________________ **Secondary Phone:** (_____) ____________________________

HEALTH INFORMATION (To be completed by all participants):

Check the following boxes (If "Yes" please explain):

□ Yes □ No Do you have any diet considerations? ____

□ Yes □ No Do you have any Drug Allergies? ____

□ Yes □ No Do you have any Food Allergies? ____

□ Yes □ No Do you have any Environmental Allergies? ____

□ Yes □ No Has any allergic reaction required emergency room care? ____

□ Yes □ No Do you have a Heart Condition? ____

□ Yes □ No Do you have High Blood Pressure? ____

□ Yes □ No Do you have any Respiratory Difficulties? ____

□ Yes □ No Are you diabetic? □ Diet controlled □ Oral medication □ Insulin

□ Yes □ No Do you wear contact lenses?

□ Yes □ No Have you had any serious illness or surgery within the past three years? If so, list with dates.

____

□ Yes □ No Have you ever been treated for anxiety, nervousness, or stress related disorders? If "yes" please explain.

____

Are you subject to: (If "yes" please explain)

□ Yes □ No Fainting? ____

□ Yes □ No Sleep Walking? ____

□ Yes □ No Frequent Upset Stomach? ____

□ Yes □ No Do you have any condition that would prevent you from participating in any activities? ______________________

____

Please indicate **ANYTHING** else that the leaders should know to help deal with any situation that might arise:

____

PLEASE LIST ANY MEDICATIONS THAT YOU WILL BE TAKING TO DOMINICAN REPUBLIC:

____

____

EMERGENCY CONTACT INFORMATION: MUST BE INCLUDED

Emergency contact: ____ Relationship:______________________________

Address: ____

(Street) (City) (State) (Zip)

Telephone: Primary (_____)________________________________ Secondary (____) ____________________________________

Primary Physician: ____ Phone: (____) ______________________