

APPLICATION
TRES M MINISTERIOS MISSION ENCOUNTER AND CULTURAL EXCHANGE EXPERIENCE

Village in the Central Interior ~ Q.ROO

January 27, 2011 – February 4, 2012

NAME: _____

(Please: as it reads on your passport)

PREFERRED NAME/NICKNAME: _____ TEE SHIRT SIZE S M L XL XXL
CIRCLE ONE

ADDRESS: _____ CITY: _____ ZIP: _____

EMAIL ADDRESS: _____

TELEPHONE: _____ WORK PHONE: _____

PASSPORT NUMBER: _____ BIRTH DATE: _____

1. WHY ARE YOU INTERESTED IN THIS EXPERIENCE? (Use additional pages if necessary)

2. WHAT DO YOU BELIEVE YOU CAN CONTRIBUTE TO THIS EXPERIENCE?

3. DO YOU UNDERSTAND THE DIFFICULT AND PRIMITIVE CONDITIONS YOU WILL HAVE TO FACE IF SELECTED TO PARTICIPATE?

4. WHAT DO YOU EXPECT TO GAIN FROM THIS EXPERIENCE?

5. DO YOU HAVE ANY PHYSICAL/or DIETARY LIMITATIONS? IF SO WHAT ARE THEY?

1. DO YOU SPEAK SPANISH?
OVER

Participant Covenant

A Tres M Ministerios mission encounter begins well before the date of departure and does not end when one returns home. Therefore, as a part of the trip and a team member, you are expected to participate fully in the orientation, trip-related activities, and any debriefing and post-trip activities. I understand that team members must be flexible, cooperative, and strive to maintain a positive attitude. I agree to cooperate at all times with the team leader concerning our trip—including daily assignments, food, lodging, and transportation. I agree to participate fully in all trip-related activities. I also certify that the information I have provided here is correct to the best of my knowledge.

Applicant's signature _____ Date _____

Please provide two emergency contacts

Name of Contact #1: _____

Relationship to participant: _____

Address: _____

Primary phone number _____

Cell phone number _____

Email address _____

Name of Contact #2: _____

Relationship to participant: _____

Address: _____

Primary phone number _____

Cell phone number _____

Email address _____

**CONSENT AND AUTHORIZATION FOR ATTENDANCE AND
EMERGENCY MEDICAL TREATMENT FOR MINORS**

_____ has my permission to travel to Mexico and Belize to attend the Tres M Ministerios Quintana Roo, Mexico, Yucatán Work Study Mission Encounter January 27, 2012 – February 4, 2012. He/she has permission to travel unaccompanied by me. I understand that he/she will travel with a group from the First Presbyterian Church of Holt, MI.; First Presbyterian Church of Howell, MI; First Presbyterian Church of Bay City, MI, First Presbyterian Church of Jackson, MI.

Birthdate _____

Medical/health insurance carrier and policy number _____

(Bring a copy of Medical Insurance cards if possible)

Allergies _____ Medications Needed _____

Blood type _____

Does Youth wear contacts? _____

Does Youth wear orthodontics retainer? _____

Phone number where parents or guardian can be reached.

If the leadership team determines that professional medical care is needed they have my permission to secure it.

*I am the Registrant's legal guardian. I am signing this release on my own behalf and on behalf of the Registrant and his/her heirs and assigns.

Parent or Guardian's signature and date

Parent or Guardian's signature and date

Notary _____

Date: _____

YUCATÁN MISSION ENCOUNTER
Physical Health Form

(Name of Participant)

(While a physical is not necessary, we encourage you to consult with your doctor or health professional*)

_____ I am in general good health and able to withstand the travels and lifestyle.

Blood type: _____

Medications: _____

Hospital/Medical Insurance Carrier and policy number: _____

I am up-to-date on or have obtained the following immunizations and medications:

<u>IMMUNIZATIONS</u>	<u>DATE</u>
• Tetanus and Diphtheria	_____
• Typhoid #1	_____
• Malaria Tablets, Chloroquine	_____
• Cipro/Bactrim/Septra	_____
• Hepatitis A and/or Immune Globulin (IG)	_____
• Hepatitis B	_____

I have the following existing medical condition(s), emotional conditions(s), or allergies of which the leadership needs to be aware:

<u>Existing Medical Condition(s)</u> <u>or Allergies</u>	<u>Special Care or Treatment</u>
_____	_____
_____	_____
_____	_____

I am a vegetarian. Yes_____. No_____.

Dietary restrictions:

over

Two people who could be contacted on my behalf in case of an emergency are the following:

1. Name (print) _____ Relationship _____
Address _____

Phone () _____

2. Name (print) _____ Relationship _____
Address _____

Phone () _____

If I have not completed the Hepatitis shot series, I will obtain a gamma globulin injection within two weeks of departure.

Signature of Participant: _____
Date: _____

Please note: The medications and immunizations required are those recommended by the Center for Disease Control for the area and conditions of this project.