

# *Cuba 4 Christ Mission Trip Application*

Mission Trip Dates: \_\_\_\_\_

Location: \_\_\_\_\_

Name of Trip Leader: \_\_\_\_\_

## **PERSONAL INFORMATION**

Name as it appears on your passport:

Passport Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Issue Date: \_\_\_\_\_

(PLEASE ATTACH A COPY OF YOUR PASSPORT PHOTO PAGE.)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (Cell): \_\_\_\_\_ Phone (Home): \_\_\_\_\_

E--mail: \_\_\_\_\_

Male/Female: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Father's Name \_\_\_\_\_

Mother's Name (Include Maiden Name) \_\_\_\_\_

Describe your previous Short-Term or Long-Term Mission Service.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why do you want to be part of this mission? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Describe how your family feels about your participation on this mission trip. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## **HEALTH INFORMATION**

Participation on a mission trip or project requires good health and physical stamina. It is recommended that you have a physical examination before participating on a mission trip or project. You should also consult with your physician if you are under his or her care or you are regularly taking medication.

1. Please state any serious illness, surgery performed or hospitalization you have had in the last five years: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Please list any known allergies (ie, Penicillin, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Please list any dietary restrictions or food allergies:

4. Please list any medications you are currently taking: (Include prescription and non-prescription drugs, dietary supplements, herbs, etc.)

5. Are you presently under the care of a physician for any medical treatment physically or emotionally? If yes, please describe:

6. Do you have a communicable disease? No \_\_\_ Yes \_\_\_  
(explain) \_\_\_\_\_

7. Do you have any chest, back, or joint pain? No \_\_\_ Yes \_\_\_  
(explain) \_\_\_\_\_

8. Do you have any limitations to strenuous physical walking or work? No \_\_\_ Yes \_\_\_  
(explain) \_\_\_\_\_

9. How would you describe your health? Excellent \_\_\_ Good \_\_\_ Average \_\_\_ Poor \_\_\_

10. Please explain any physical challenges that you may face on this mission trip:

Briefly describe any major life changes you have gone through recently (job, family changes, illness, injury, or death of a relative or close friend, etc.)

Would any of the above changes interfere with your ability to fulfill your commitment on this short-term mission trip?

Yes \_\_\_\_\_ No \_\_\_\_\_

Blood Type: \_\_\_\_\_ Can you donate blood? Yes \_\_\_\_\_ No \_\_\_\_\_

Identifying Marks:

### VACCINATIONS

The Centers for Disease Control [www.cdc.gov](http://www.cdc.gov) divides vaccines for travel into three categories: All travelers, Most travelers and Some Travelers. You should consult your doctor for information regarding which vaccines you should receive. To participate in a Cuba 4 Christ, Inc. Mission Trip you must have the vaccines that "All Travelers" are listed as needing. We strongly suggest you also have the vaccines for "Most Travelers".

Dates of Last Immunizations:

Td/Tdap: (Tetanus) \_\_\_\_\_ MMR: \_\_\_\_\_ Polio: \_\_\_\_\_

Hep A: \_\_\_\_\_ Typhoid: \_\_\_\_\_

Hep B: \_\_\_\_\_ Cholera: \_\_\_\_\_ Yellow Fever \_\_\_\_\_ Malaria: \_\_\_\_\_

**HEALTH INSURANCE**

Name of Health Insurance Company:

\_\_\_\_\_  
Policy/Group Number: \_\_\_\_\_ Phone: \_\_\_\_\_

(PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.)

**EMERGENCY CONTACTS**

Full Name of Emergency Contact (1):

\_\_\_\_\_  
Contact Phone (Day): \_\_\_\_\_ Phone (Evening) \_\_\_\_\_

Emergency Contact E--mail:

\_\_\_\_\_  
Full Name of Emergency Contact(2):

\_\_\_\_\_  
Contact Phone (Day): \_\_\_\_\_

Phone (Evening): \_\_\_\_\_

Emergency Contact E--mail: \_\_\_\_\_

Beneficiary: \_\_\_\_\_

Relationship: \_\_\_\_\_

Beneficiary Email: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Medical Permission: This is only for emergency situations should the individual be incapable of making rational decisions. In any situation, every effort will be made to reach your emergency contacts listed on this application.

In the event an emergency arises, I give the trip leader permission to authorize anesthesia, surgery, and/or procedures deemed absolutely necessary at the time.

Participant acknowledges that participation in the above trip involves risk to the Participant and may result in various types of injury including, but not limited to the following: sickness, bodily injury, death, emotional injury, personal injury, property damage and financial damage.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

U.S. Personal Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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