Project World, Inc.
Mission Trip Information Packet

Personal Information

Name (as stated on Passport): _____

Address: _____City: _____Zip: _____

Mobile #: _____

Email Address: _____

Date of Birth: _____ Age: _____ Grade: _____

Gender: _____Female _____Male Marital Status: _____Married _____Single

Passport #: _____Expiration date: _____

Be sure to CHECK your passport!! In order to enter Honduras, your passport CANNOT expire 6 months from the date of departure.

In the event of an Emergency, please notify:

Primary Contact: _____ Relationship: _____

Mobile #: _____ Email:_____

Secondary Contact: _____ Relationship: _____

Mobile #: _____Email: _____

Medical History and Information

Do you have medical insurance coverage? ____Yes ____No Does coverage include international? _____Yes _____No Name of Provider: _____

Policy Holder's Name: _____ Policy ID#_____

General health of participant: _____Excellent _____Good _____Fair _____Poor

Do you have any chronic medical conditions? _____Yes _____No If yes, please explain.

List any medications you are currently taking and will be traveling with to Honduras.

1. _____ 3. _____

2. _____ 4. _____

Do you have any allergies? (check all that apply) Are any life threatening? ___Yes ___No

_____Plants _____Animals _____Molds _____ Drugs _____Insects _____Other

Please explain the allergic reaction and the treatment for each checked allergy.

Release for Travel and Medical

Notice: This is a binding legal document. Please read carefully and sign. Consult an attorney if you have any questions. It is a release of claims and hold harmless for future accidental injuries or death of minor or participant and authorization for emergency medical or dental care to minor or participant.

1 (a) I, the undersigned, the parent or the legal guardian, of the minor listed below:

_____

Participating Minor's full name Birth date (MM/DD/YEAR)

1 (b) I, the undersigned, a legal adult, listed below:

_____

Participating Adult's full name Birth date (MM/DD/YEAR)

agree to the travel and medical release for the **Mission trip to Honduras w/ Project World, Inc.**

2. I have inquired about the activity to my satisfaction and am aware of all the inherent dangers of the above activity and the benefits to be gained by the minor/participant engaging in the activity.

3. By signing this form, I understand and agree that neither Project World, nor its agents, officers, directors, employees, or ministry partners may be held liable in any way for any occurrence in connection with the above activity which may result in injury, death, or other dangers to the minor/participant or his or her heirs, family, or assigns.

4. For being allowed to participate in the above activity, I (on behalf of the minor/participant) personally assume all risks in connection with the activity. I release Project World, its agents, officers, directors, employees, or ministry partners from any injury or damage, which may befall me/the minor while he or she is engaged in the above activity. This release includes all risks connected with the activity, whether foreseen or unforeseen. I further agree to save and hold harmless Project World and the above named persons from any claim by me or the minor, or the family, estate, heirs, or assigns arising out of his or her participation in the above activity.

5. I authorize any x-ray examinations, anesthetic, dental, medical, or surgical diagnosis or treatment by any physician or dentist licensed by the State or Country in which such treatment is needed; any ambulance or hospital service that may be rendered to the minor/participant named above under the general, specific, or special consent of the acting agent of Project World, the temporary custodian of the minor/participant, whether such diagnosis or treatment is required at the office of the physician or dentist, or at the hospital licensed by the State in which such treatment is needed. I further authorize the physician or dentist to call in any necessary consultants at his or her discretion and to exercise their discretion in authorizing the disposal of any severed tissues or member.

I understand that this consent is given in advance of the specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor/participant, and said physician or dentist to exercise his or her best judgment as the requirements of such diagnosis or medical, dental or surgical treatment. I understand that neither Project World nor any person having temporary custody of the minor assumes responsibility for the payment of the ambulance, doctor, dentist, or hospital fees; that is my responsibility; however, if out of pocket expenses are covered by Project World or any person having temporary custody of the minor, an Assignment of Benefits will need to be completed and signed for reimbursement.

This consent shall remain in effect unless revoked in writing, delivered to the said physicians or dentists or the said persons entrusted with the temporary custody, care, and control of the minor child/participant named above.

6. Further I give my permission for any and all pictures, audio, videos, or personal testimonies to be used in part or in whole in any and all future publications printed or recorded, (audio or video), without prior notification or royalties.

7. Furthermore, I state that (a) I am of legal age and legally competent to sign this agreement and release; (b) I understand the terms in this agreement and release are contractual and not a mere recital; (c) I have fully informed myself of this agreement and release by reading it before I signed it; (d) I have had the opportunity to consult with legal counsel regarding the effect of this agreement and release, should I so desire; and (e) I have signed this document of my own free act.

Dated this_____ day of_____20_____

_____ _____

Full legal name of Applicant (please print) Signature of Applicant

☐ATTACH a copy of Passport

☐ATTACH a copy of Insurance Card (front & back)

☐COMPLETE the section below only if applicant is a minor

By signing, I assert that I have legal custody or am a legal guardian of the minor listed above.

_____ _____

Signature of Parent or Legal Guardian Date