



# Mission Trip Application

Word & Worship Church  
1200 Wolfe Avenue  
North Braddock, PA 15104  
WORDANDWORSHIP.ORG

Please print clearly:

I am applying to go on the Mission Trip to: \_\_\_\_\_

Dates: \_\_\_\_\_

## Personal Information

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Nickname: \_\_\_\_\_

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

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

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

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

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male Female (circle)

Have you previously gone on any mission trips? Yes No (circle)

If yes, where did you go, and when? \_\_\_\_\_

Connection Group Leader: \_\_\_\_\_

If required, do you have a passport? \_\_\_\_\_

## Finances

Cost of trip: \$ \_\_\_\_\_

How do you plan to raise funds for this trip? (i.e. from your savings, support letters, fundraisers) \_\_\_\_\_

You may request fund from Word & Worship Church toward the cost of this trip. Each request will be reviewed on an individual, as needed basis. Requests for financial assistance must be made 60 days prior to your departure date. Church sponsored support applies to Word & Worship church members and their children only.

If you need church assistance with funds, how much are you requesting? \$ \_\_\_\_\_

A \$20.00 non-refundable fee is required when you submit an application. This money will be used toward the cost of your mission trip.

## Medical Information

Name of Health Insurance Provider: \_\_\_\_\_

Policy # \_\_\_\_\_

Are you under a doctor's care for any condition?    Yes    No    (circle)

If yes, please explain: \_\_\_\_\_

Are you currently taking any medications?                      Yes    No    (circle)

If yes, please explain: \_\_\_\_\_

Do you have any physical handicaps which require special attention?    Yes    No    (circle)

If yes, please explain: \_\_\_\_\_

*Please circle any that apply and explain in space provided:*

Allergies	Mental Disorder	Back Problems	Venereal Disease
Skin Conditions	Nervous Disorder	Eating Disorder	Cancer
Eye Trouble	Insomnia	Tuberculosis	Females: Irregular and/or excessive Periods
Ear Trouble	Heart Trouble	Stomach Ulcer	Severe Cramps
Head Injury	High Blood Pressure	Intestinal trouble	Other
Headaches	Low Blood Pressure	Diabetes	Other
Epilepsy	Rheumatism	Kidney Disease	Other
Fainting Spells	Arthritis	Anemia	Other

### In case of an emergency please contact:

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

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

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

Or

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

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

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

**Permission Form for Minors (under age 18)**

I hereby certify that my child, \_\_\_\_\_, has permission to participate in the mission trip to \_\_\_\_\_ with Word & Worship Church from \_\_\_\_\_ to \_\_\_\_\_ (dates).

I understand that my child will be under the supervision of representatives of Word & Worship Church. I understand and agree that this release shall hold harmless Word and Worship Church and any leader or responsible person involved in the mission trip from any and all liability relating to my child, from all personal injury or illness that my child may suffer, and from any loss of property that may occur to my child during this mission trip.

Parent's Name: \_\_\_\_\_  
Please print

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Permission Form for Minors (under age 18)**

In case of emergency, I give permission to the mission trip leader(s) and its representatives to obtain medical treatment for me my child, \_\_\_\_\_, in my absence.

Name of Health Insurance Provider: \_\_\_\_\_ Policy # \_\_\_\_\_

Parent's Name: \_\_\_\_\_  
Please print

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_