WORK PLAY LOVE

workplaylove.org

Name and dates of your trip _____

Registration Form

YOUR INFORMATION

_____
Full Name (AS IT APPEARS ON YOUR PASSPORT)

_____
Address

_____
City/State /Zip

Phone Work Phone _____
_ _

_____
E-Mail Address

_____
Birth Date (mo/day/yr) Age Gender M/F

GROUP or CHURCH INFORMATION

_____
Name Denomination

_____
Address

_____
City/State/Zip

_____
Pastor

(_____)_____
Group or Church Phone

EMERGENCY CONTACT INFORMATION

Parent/Guardian or Spouse Info: Include titles (Dr., Rev., etc.)

_____
Name(s) Relationship

_____
Address (if different)

_____
City/State/Zip

(___ _ ___)_____ _ (___ _ ___)_____
Phone Work Phone

_____
E-Mail Address

Alternate Emergency Contact Info: Include titles (Dr., Rev. etc)

_____
Name(s) Relationship

_____
Address (if different)

_____ City/
State/Zip

(___ _ ___)_____ _ (___ _ ___)_____
Phone Work Phone

_____ E-
Mail Address

Do you have any special skills that you are bringing to this mission trip? (e.g. speak Spanish, teacher, manual labor, doctor, nurse, construction, etc)

_____

Will you be celebrating any special days while on the trip? (birthday, anniversary, etc)_____

If you can, please SCAN this form and send it electronically to Kim@KimMelia.com This is the most efficient way to do this.

Please return this form to:
Kim Melia - Kim@KimMelia.com

I, _____, state that the information included in this application form is true and accurate, to the best of my knowledge. I further agree to cooperate with my crew, and conduct myself in order to fulfill the goals of this mission trip.

Signed:_____ Date:_____

Physician's Statement and Health History

Patient's Name_____ **Birth Date** ____/____/____
Last First Middle Initial mo. day yr.

Sex: Male Female (please circle) **Height**_____ **Weight**_____

Dates of Trip: _____

Note to Physician: Activities include:

- Air travel up to 1 day in length, vehicular travel up to 4 hours, walking on cobblestone up to a mile.
- Manual labor on the average of nine hours per day over a one to two week period; labor may include painting, shoveling, carrying loads, planting activities, other physical activities.
- Less than adequate rest at times.
- Exposure to many different foods, often unusual in comparison to one's normal diet
- Stress from communal living and from witnessing trauma associated with children in poverty.
- Traveling and living in developing nations.

The above individual has been examined by me and I find him/her: (please check)

____ Qualified for the Guatemala Trip with no restrictions.

____ Qualified for activities but has a minor condition(s) that will not interfere with participation.
Explain, if necessary._____

_____

____ Qualified for the Guatemala Trip with the following recommended restrictions:

_____

____ This individual is, in my estimation, not qualified for a Guatemala Trip per the activities as suggested.
Reasons for this have been fully discussed with the individual concerned.

Physicians Signature_____ **Phone** (___) _____

Name (please print) _____ **Date** _____/____/_____

Please check any applicable items and explain in section below:

HEALTH ISSUES
____ Physical
____ Emotional

REQUIRED RESTRICTIONS
____ Activities
____ Diet

IMMUNIZATIONS (Please list most recent dates)
____/____/____Tetanus*
____/____/____Polio
____/____/____Measles/Mumps/Rubella
____/____/____ Hepatitis A*
____/____/____
____/____/____ Hepatitis B*
____/____/____
____/____/____
***Strongly Recommended**

MEDICAL CONDITIONS
____Knee problems
____Back problems
____Asthma
____Attention Deficit Disorder
____Menstrual Pain
____Acne
____Chemical Imbalance

ALLERGIES
____Medications
____Bee stings
____Pollen
____Dander
____Food
____Other_____
_____
_____

Please explain any **HEALTH ISSUES, MEDICAL CONDITIONS, REQUIRED RESTRICTIONS** (Vegetarian menus cannot always be accommodated), **ALLERGIES or MEDICAL CARE** that Guatemala Trip needs to be aware of: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list any **SPECIAL MEDICATION.** If so, explain for what reason and how often? Please state need for any staff or counselor supervision or allocation._____

_____
_____
_____
_____
_____
_____
_____

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Medical Information and Authorization

Please Print and Use Black Ink Pen

Name_____ Social Security__-__-____
Last First Middle Initial

Dates of Trip _____

Please put a (C) after a phone number for a cellular phone. Thank you.

Father's Name_____ Day Phone (___)_____ Evening Phone (___)_____

Father's Address_____ City_____ ST_____Zip_____

Mother's Name_____ Day Phone (___)_____ Evening Phone (___)_____

Mother's Address_____ City_____ ST_____Zip_____

Spouse/Other_____ Day Phone (___)_____ Evening Phone (___)_____

Spouse/Other_____ City_____ ST_____Zip_____

If unable to reach any of the above, please list two additional contacts

Name	Relationship	Day Phone Number	Evening Phone Number
1. _____	_____	(___)_____	(___)_____
2. _____	_____	(___)_____	(___)_____

Medical Clinic and Physician

Name of Clinic_____ Phone (___)_____

Clinic Address_____ City_____ ST_____Zip_____

Name of Primary Care Doctor(s)_____ Phone (___)_____

Doctor's Address_____ City_____ ST_____Zip_____

Insurance – *WE REQUIRE A PHOTO COPY OF A CURRENT INSURANCE CARD/DOCUMENT*

Person Responsible for Payment_____ Relationship_____

Name of Employer_____ Phone (___)_____

Employer Address _____ City_____ ST_____Zip_____

Name of Insurance Company_____ Phone (___)_____

Address _____ City _____ ST_____Zip_____

Policy Number_____ REMINDER: *Please send a copy of current insurance card*.

I hereby approve registration as ☐ myself _____ or

☐ parent or ☐ legal guardian of (name) _____
and give permission to take part in the Guatemala Trip. I voluntarily waive any claim against Work, Play, Love, Kim Melia, Facility Owners and staff, team leaders, volunteers, and any minors or contacts for any mishap or lost articles, or any and all accidents injuries and illnesses that may arise in connection with the Guatemala Trip activities. In addition, I realize that if trip leaders have to secure proper medical treatment for the above named person, they have my permission to do so. If those listed above cannot be reached at the above given numbers, I hereby authorize Kim Melia, and/or authorized persons to sign for necessary emergency and/or general medical treatment. This includes x-rays, injections, and surgery for the above named person during the time they participate in this Guatemala Trip. In a case of an emergency, all attempts will be made to contact the parent, legal guardian or spouse prior to medical treatment.

My signature verifies that all information given on this form is correct to the best of my knowledge.

_____ Date_____ 20_____
BLACK INK signature – Parent, Legal Guardian, Self

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or Kim@KimMelia.com

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Name and dates of your trip _____

PARENT PERMISSION FORM

To whom it may concern:

I/We_____

parent(s) or guardian(s)

give permission for **my/our child** _____ to participate in a Guatemala Team Trip traveling to Guatemala.

I/We _____

parent(s) or guardian(s)

give permission for the designated trip point of contact and/or the applicable persons to make all health and medical decisions for my/our child during the duration of the Guatemala Trip, _____(please list dates of trip).

I/We understand that full effort will be made to contact and discuss any major treatment with **me/us. I/We** understand that communication can be erratic, difficult, and sometimes impossible internationally.

I/We _____

parent(s) or guardian(s)

give permission for **my/our child** _____ to be transported across country borders if necessary for medical treatment and/or evacuation.

I/We _____

understand that **my/our child** _____ may be in proximity to and/or participating in activities with children who may be HIV+.

Father:_____ _____ _____

print full name | signature | date

Mother:_____ _____ _____

print full name | signature | date

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