Trip Application / Medical Release / Permission to Treat Form

Team Information

Team Leader: ____

Trip Location: ___________________________________ Trip Dates: ________________

Personal Information

Full Name: ____ Gender: ___________

SSN: ________________________________ DOB: ____________________ Age: __________

Address: ____

City: ____________________________________ State: ________ Zip Code: _____________

Home Phone: ____________________________ Cell Phone: ____________________________

Email Address: ____

Parent/Guardian (if younger than 19 years old): ____

Do you have any special skills or training specific to working with children or in the medical field? _________

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____

Emergency Contact Information
Please provide the name and contact information of two individuals not traveling with your team who may be contacted in the event of an emergency.

Name: ____

Relationship to You: ____

Phone: _______________________________ Alt. Phone: ____________________________

Name: ____

Relationship to You: ____

Phone: _______________________________ Alt. Phone: ____________________________

Insurance Information
Please attach a copy of the front and back of your insurance card.

Insurance Company: ____

Policy Holder: ____________________________________ Relationship: __________________

Policy #: ____ Group #: ______________________

Ins. Co. Address: ____ Phone: ________________

Name of Travel Insurance Beneficiary: ____

Medical Information

Primary Care Physician: ____

Physician Address: ____ Phone: ________________

Do you have any allergies? _____ yes _____ no

If yes, please explain: ____

____

List any specific medical conditions requiring medical treatment and/or medication: ____________________

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List ALL medication taken on a regular basis: ____

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List all operations/serious injuries (include dates) within the past five years: _______________________

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Have you had contact with contagious or infectious diseases within the last four weeks? _____ yes _____ no

If yes, please explain: ____

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If this is your first trip with Westwood please give a brief testimony. ________________________________

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Westwood Mission Refund Policy _____________ initial

Due to IRS regulations, Westwood follows a stringent “no refund” policy for all donations received. In the event you are unable to go on the scheduled mission trip all funds minus the $100 non-refundable deposit donated will be held over one trip year to send that same missionary or another trip goer at WWBC discretion. After that one year the funds will be moved to the general mission fund.

Fees, Contributions & Tax-Deductions

1. All donations must include missionaries name and trip attending
2. All check/money orders must have current dates (not postdated) and are made payable to Westwood Baptist Church to ensure tax deductibility.
3. To receive a tax deduction, sponsors must make their checks payable to Westwood Baptist Church. Westwood Baptist Church is recognized by the IRS as a tax-exempt organization described in the Internal Revenue Code Section 501 (c) (3) and is eligible to receive tax deductible donations. All contributions to WWBC are solicited with the understanding that WWBC has complete discretion and control over the use of all donated funds.
4. Contributions are NOT refundable. All funds donated by sponsors become the exclusive and permanent property of WWBC when received and are at all time under the complete discretion and control of WWBC. Donated funds will be used in furtherance of WWBC tax-exempt purposes for mission work and evangelism.
5. Sponsors are NOT to place the missionary's name anywhere on the check. When sponsors send in a check please use the provided mission envelopes or include a sticky note with the person's name and trip location on it.
6. All trips and scheduled ministry are subject to change due to unforeseen circumstances that may arise.

Emergency Authorization

I hereby give permission to medical personnel selected by my team leader or his/her designee (hereafter the Authorized Agent) to order X-rays, routine tests, and treatment for me. In the event of an emergency and neither my primary nor secondary contact can be reached, I hereby give permission to the physician selected by the Authorized Agent to secure proper treatment, hospitalize, order injections and/or anesthesia, and/or authorize surgery for me.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release WBC, its employees or agents, and in country contacts from liability associated with participation in a mission trip. I understand that if I do not have medical insurance, I will be responsible for any medical expenses in the event of a sickness or injury.

I understand that there are risks involved in participating in a mission trip.

Signature: ____ Date: ______________________

(Must be signed by a parent or guardian if under 19 years of age.)

The following is to be completed by the Notary Public witnessing the individual's signature.

The State of ____________________________ the County of ____________________________

Before me, a Notary Public, on this day personally appeared ______________________________

known to me (or proved to me on the oath of ____) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this ______________ day of ________________, A.D. __________________.

Notary Public Signature ____

My commission expires the _____________ day of __________________, A.D. _____