



# FIRST CONGREGATIONAL CHURCH

## H.O.M.E. Mission Trip

### Participant Information

Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

E-Mail: \_\_\_\_\_

#### NAME OF PARENT OR GUARDIAN:

Name(s): \_\_\_\_\_

Telephone (home): \_\_\_\_\_ Telephone (cell): \_\_\_\_\_

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

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

Parent(s) Email: \_\_\_\_\_

Home Trip Returnee	Y <input type="checkbox"/>	N <input type="checkbox"/>
FCC Member	Y <input type="checkbox"/>	N <input type="checkbox"/>
Current Grade	_____	
Sex	F <input type="checkbox"/>	M <input type="checkbox"/>
Mandatory Community Service	Y <input type="checkbox"/>	N <input type="checkbox"/>

#### IF PERSON NAMED ABOVE IS NOT AVAILABLE IN THE EVENT OF EMERGENCY, NOTIFY:

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

Telephone (home): \_\_\_\_\_ Telephone (cell): \_\_\_\_\_

#### HEALTH / MEDICAL INFORMATION:

Allergies: Yes  No  Explanation: \_\_\_\_\_

#### General Information: Circle any that apply

*Convulsions/seizures*   *Asthma*   *Diabetes*   *Cancer/Leukemia*   *Heart trouble*   *Kidney disease*

*Wears glasses/contacts*   *Surgery/Hospitalization*   *Other*

Explanation: \_\_\_\_\_

Please list all **medications** taken in the 30 days prior to the trip:

\_\_\_\_\_  
List any medications to be taken while on trip (prescription & over the counter):

\_\_\_\_\_  
List any physical conditions that may affect participation in any activities:

Date of last Tetanus immunization: \_\_\_\_\_

All this information will be kept in the strictest confidence. As we will be entrusted with the care and well-being of your child, it is imperative that we have as much information as possible in order to make the best decisions if the need arises.

Further, I give my permission (consent for my minor child or ward) to be treated by competent medical personnel as a result of any accident or medical emergency while involved in the activities of H.O.M.E. I understand that in the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation in the H.O.M.E. project, every reasonable effort will be made to contact the persons listed on the reverse side. If the listed persons cannot be reached, I authorize the adult(s) accompanying me (or my minor child or ward) on the H.O.M.E. project to secure competent medical treatment for me (or my minor child or ward), including on the recommendation of qualified medical personnel, hospitalization, injections, anesthesia, or surgery.

I agree that my insurance company will be used for such medical care expenses and I acknowledge that I am responsible for any medical expenses not covered by my insurance. I agree to allow any photos taken of me during, before, or at clean up of this trip to be used as promotional collateral at FCC, in the trip DVD, on the FCC website, and in any local News articles about the trip.

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

\_\_\_\_\_  
Participant Signature/I certify I am 18 years of age or older      OR      Signature of Parent or Guardian of Minor Participant

\_\_\_\_\_  
Signature of Minor Participant