



**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? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List ALL medication taken on a regular basis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

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

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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.)*



## Release of Liability

In signing this form, I, \_\_\_\_\_, agree not to hold Westwood Baptist Church (WBC), her officers, employees, or other agents liable for any injury, loss, damage, or accident that I might encounter while on a short-term missions event/effort.

I realize and acknowledge that my participation on a mission trip to a foreign country includes risk and possible dangers. I am well aware that my travel to such a foreign country exposes me to such risks as accidents, disease, war, political unrest, injury from construction projects, and other calamities.

I hereby assume any such risks that might result from my participation in a short-term missions project, and I unconditionally agree to hold Westwood Baptist Church (WBC), its officers, employees, or other agents blameless for any liability concerning my personal health and well being, or any liability for my personal property that might be lost, damaged, or stolen while on a short-term mission trip.

Signed: \_\_\_\_\_

Parent's Signature (if under 19 years of age): \_\_\_\_\_

And dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**The following is to be completed by the Notary Public witnessing the individual's signature on this application and liability release:**

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. \_\_\_\_\_.