**Medical Release Form**

Team Member's Name_____ Social Security # _____
Name of person to be contacted in case of emergency _____
Work and Home Phone of person who should be notified in case of an emergency
Work: (_____) _____ Home: (_____) _____

Health Insurance Company _____ Health Insurance Policy # _____
Health Insurance Phone (____) _____

Describe any medical problems, medications you are taking. etc., that would assist in your treatment should you become ill. The name and phone number of your family doctor would be helpful.
Doctor Name: _____ Phone: (____) _____

I give permission in case of injury or illness for the leaders to seek medical attention for the above group member as may be required. Also, I understand the registrant should provide personal insurance to cover illness, accident, or injury as Teens For Christ or the missions leadership assumes no liability for such occurrences.

_____ _____
**Parent or Legal Guardians Signature** **Date**

* In case of sickness or accident please complete the following:
Your Hospital Insurance Company : _____
**Policy Number**: _____ **Group #**: _____
*(Please double check your numbers for accuracy)

I hereby give permission to medical personnel with proper credentials to give emergency medical treatment and care to the above named program participant.

_____ **Date**: _____
(**Must be signed by parent or legal guardian**)

* Does the participant have any allergies to medicines, food, or bee-stings, etc?

*Does the participant have any medical conditions such as diabetes, asthma, heart problems, depression, ADD, ADHD, or any physical exercise limitations? (If yes, please explain)
*Name and exact dose of medications that your child is taking. Please state the reason for taking it. Example: 20 mg. Zoloft taken every morning, for depression. (Use separate sheet of paper is necessary.)

Name: _____, has my permission to take the following over the counter medicines:

| | YES | NO |
|---|---|---|
| 1. Tylenol or Ibuprofen for headaches, pain, or fever | ____ | ____ |
| 2. Benadryl, Calamine, or Caladryl lotions for insect bites/skin irritations- | ____ | ____ |
| 3. Antacids (Turns) or Pepto Bismal for upset stomach- | ____ | ____ |
| 4. Antibiotic cream such as Bacitracin for cuts and scrapes- | ____ | ____ |

_____ _____
**Legal Guardians Signature** **Date**

# PERSONAL TESTIMONY

Please use the following space to give your personal testimony of how you became a born-again Christian, including the date of your conversion if known:

Please give three or more reasons why you are interested in being a part of this mission:

Please list three or more strengths you have that will benefit the missions team:

Please state your position and personal standards regarding areas such as music, movies and videos, alcoholic beverages, non-perscription drugs, and tobacco:

# Mission Trips
## CHARACTER REFERENCE

Please give this reference and the enclosed envelope to your youth pastor or pastor! _____
(_____)_____is applying for a position on our missions team. Teens Name Teens Phone #

He/she would like you to send us a character reference. We would appreciate your personal evaluation of this person's potential as part of our missions outreach team.

1. How well do you know the applicant: Casually: ___ Well: ____ Very Well: ____

2. How long have you known the applicant? _____years _____months

3. What is your appraisal of the applicant's Christian life? (his/her conversion and growth)
_____
_____

4. PLEASE GIVE YOUR OBSERVATIONS IN THESE AREAS:
Relationship with the opposite sex:

Ability to get along with others:

Willingness to accept responsibility:

Willingness to respond to authority:

Applicant's strong points:

Applicant's weak points:

Use of tobacco, alcohol, or non-prescription drugs:

**5. How do you rate the applicant in these areas?** (Please rate on a scale from 1 to 10)
10 = Excellent; 5 = Average; 1 = Poor; NCO = No Chance to Observe

| | Rate: | Comments: |
|---|---|---|
| Reliability: | | |
| Maturity: | | |
| Emotional Stability: | | |
| Problem Solving: | | |
| Verbal Expression: | | |
| Sensitivity to Others: | | |
| Leadership Abilities: | | |
| Personal Appearance: | | |
| Personal Integrity: | | |
| Acceptance by Others: | | |

6. Please give your frank appraisal, either favorable or unfavorable, of the applicant's potential for working with other teenagers and adults as part of our mission team.

7. Can you recommend him/her as a responsible leader? (Please check one of the following)
Yes_____ No_____ Yes, (with some reservations) _____

8. If you had a son or daughter who were also on our mission trip, would you trust your child with this student?
Yes_____ No _____

_____

Signed:_____ Date: _____
Office Phone: (_____) _____ Home Phone: (_____) _____
Full Name (type or print):_____
Occupation:_____
Address:_____ City:_____ State: ____ Zip:_____

Thank you for your assistance
Chadp@teens4christ.com

**Please mail or fax this form immediately to:**
Teens For Christ
% Missions Director
PO BOX 920
Hudson, WI 54016
Fax: 715-386-2553
Phone: 715-386-2549