

Youth Missions Application & Release Form

Please mail with \$100 deposit by July 9th to:
Youth Missions Adventure
PO BOX 2168
Alma, AR 72921

Thank you for your interest in the 2010 Missions Adventure to Kayenta, AZ. This missions trip is from July 23rd to July 31st for youth ages 14-24. The cost for this trip is \$350, of which \$100 is due by July 9th. This includes all meals, lodging, transportation, T-shirt, and Amusement Park. Please remember that space is limited to only 20 students for this trip.

PLEASE PRINT ALL INFORMATION

Name _____ Male () Female () D.O.B. ____/____/____
Address _____
City _____ State _____ Zip _____
Email address: _____ T-Shirt Size: _____
Parent/Guardian Names _____
Phone Number _____ - _____ - _____ Alternate Phone Number _____ - _____ - _____
Home Church _____
Pastor's Name _____ Pastor's Phone Number _____ - _____ - _____

ALTERNATE EMERGENCY CONTACT:

Name _____ Phone Number _____ - _____ - _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you born again?
 Yes No Date: _____
Are you filled with the Holy Ghost, with the evidence of speaking in tongues?
 Yes No Date: _____
Are you attending Sr. Camp this year (June 9-13th)?
 Yes No If no, please explain why not. _____

What areas of ministry do you feel that God has called / gifted you in?

Please write a short paragraph explaining why you want to go on this Missions Trip.

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ABSOLUTE RELEASE OF LIABILITY (This form must be signed by student and guardian)

MEDICAL AUTHORIZATION: In consideration of the opportunity to the Pentecostal Church of God Youth Missions Adventure and for other valuable consideration, I, _____ (parent) hereby certify that _____ (student) is in good health, free from all communicable diseases. I give my full permission for said student to participate in any and all activities. In case of medical and/or surgical emergency, I hereby authorize the Physician or Hospital selected by the camp administration to hospitalize, secure proper and appropriate treatment for, and/or order injection, anesthesia and/or surgery for my child (named above) as necessary and this authorization shall serve as a Limited Power of Attorney in accordance with the laws of the State of Arkansas in that regard.

In case of injury or illness, I understand that my primary insurance will be billed first and that the Arkansas District liability insurance will be billed as a secondary provider.

RELEASE OF ALL CLAIMS: With a full and intelligent understanding of my rights and privileges and the rights and privileges of my child named above, I hereby knowingly and designedly waive any and all claims in regard to the potential liability of the Pentecostal Church of God, its Boards, representatives, employees, youth ministry personnel and agents.

PROPERTY LOSS: I further understand that the Pentecostal Church of God, it's Boards, representatives, employees, youth ministry personnel and agents are not responsible for lost, stolen, or damaged items belonging to the above named student. I assume full financial responsibility for any items damaged, destroyed or stolen by or from the above student. In the event the student must return home because of discipline or health reasons, I agree to pay transportation cost and understand that the registration cost will not be refunded.

ACTIVITY RELEASE: I give my child (named above) permission to participate in any and all activities, whether on or off campus. I also give the Pentecostal Church of God permission to transport my child to said events, and will not hold them responsible for any accident or injury that may occur during these activities or during transportation to and from.

FOLLOWING RULES: I _____ (student) will follow the rules set forth by the missions director and will conduct myself in a Godly manner bearing in mind that I am an example to others.

_____/_____/_____
(Student) (Date)

_____/_____/_____
(Parent or Guardian) (Date)

MEDICAL INFORMATION:

Allergies: (medicines, foods, insect bites, etc.)

Please note any current health problems or disabilities:

List any medications that must be taken:

Date of Last Tetanus Shot ____/____/____

Family Doctor: _____ Phone # _____ - _____ - _____

Health Ins. Co. _____

Policy # _____ Acct. # _____