

VCC Mission Team Student Application

Attach recent photo here
(Approximately 2"x2")

Name

Date Received by VCC

2010 Team

Guatemala
June 18th—28th



Mail: P.O. Box 1088, Albany, OR 97321
Location: 577 Scrael Hill Rd
Phone: 541-967-8712 Fax: 541-967-6120
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Website: www.vccalbany.com

Guatemala 2010 Application

Student Information

Personal Data

1. Full Legal Name _____

What would you like to be called? _____

2. Gender: male female Date of Birth _____

3. Home Address _____ City _____ State _____ Zip _____

4. Phone _____ E-mail _____

Travel Documentation (Passport **required** for all trips outside the USA.)

5. Do you have a current passport? _____ Passport # _____ Expires _____

Emergency Contact Information

6. Name _____ Relation _____

7. Address _____ City _____ State _____ Zip _____

8. Home Phone _____ Work Phone _____ Cell Phone _____

Church Information

9. Pastor's Name _____ Church Name _____

10. How long attended? _____ Areas of involvement _____

Special Skills

11. List any foreign languages you speak, read or write and rate your level of proficiency in each: excellent, good, fair or poor. _____

12. Do you play an instrument? _____ Which? _____

13. If you play guitar and lead worship would you be willing to bring your guitar on the trip? _____

14. Have you ever been involved in:

Leading Worship Drama Teaching Children Puppets Crafts

Leading Prayer Groups Street Evangelism Construction Preaching

15. What other cross-cultural experience or foreign travel experience do you have?

Experience	Dates	Description of Experience/ Travel
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Guatemala 2010 Application

Student Information

Personal Information

16. Please give the dates of the following experiences in your life:

Conversion _____ Water Baptism _____ Baptism with the Holy Spirit _____

On a separate sheet of paper, please identify the entry by number and write a brief response to the following questions:

17. Describe your experience of conversion to Christ.

18. Describe your experience of water baptism.

19. Describe your experience of baptism with the Holy Spirit.

20. Describe your spiritual growth in Christ over the past year. Include victories, healings, struggles, devotions, answers to prayer, etc.

Please include the following items with this application.

- A recent photo
- Application
- Letter of recommendation from parent
- A handwritten letter explaining why you want to serve on this team.
- All release forms (parental, medical consent and medical assessment)

Parental Release Form

Parents, we at Valley Christian Center Foursquare Church (VCC) want you to feel confident about the safety and security of your teen while they are participating on this team. We understand your concerns and will give special care to help ease them.

We invest a lot into our leaders to assure the best possible experience for your teen in ministry, discipline, accountability, and safety. The team leaders are responsible for the teams throughout the mission trip. Team leaders handle the daily schedule, discipline and spiritual environment for the team. In addition, youth pastors and their adult leaders are accountable for their individual teams. All leaders are 21 years of age or older and are responsible for establishing relationships and watching out for your teen. These leaders are personally screened and proven in ministry.

If you would like to speak with someone regarding the leadership of this trip, feel free to call our office and we will assist you.

I have read and understand the above statement.

Parent/guardian signature

Date

Guatemala 2010 Application

Medical Assessment

Please answer all questions. If you need more space for explanations, attach a separate piece of paper.

Name of Applicant _____ Date of Birth _____ Trip Name _____

In case of medical emergency, who should be contacted?

Name _____ Phone (work) _____ (home) _____ (cell) _____

Address _____

Name _____ Phone (work) _____ (home) _____ (cell) _____

Address _____

How do you appraise your present health ? Excellent Good Fair Poor

Childhood Immunizations (These must be up-to-date)

Medical History

Type:

Mumps / Measles / Rubella

Diphtheria / Pertussis / Tetanus

Polio

Tetanus

Other:

Year Immunization given: _____

Are you allergic to any medications? If "yes," please explain.

Are you currently taking any prescribed medication? (If yes, please specify the medication and dosage.)

Yes No _____

Yes No

- Asthma or chronic wheezing
- Emphysema or other lung and/or respiratory problems
- Chronic persistent cough or shortness of breath
- Tuberculosis
- Any skin disorder or disease other than acne
- Recurring ear or eye problems, impairment of hearing or vision, meniere's disease, cataracts or glaucoma
- Persistent, recurring indigestion, stomach or duodenal ulcers
- Gall bladder stones or colic
- Jaundice, cirrhosis or other liver problems
- Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding
- Any test results indicating exposure to the AIDS virus
- Albumin, blood or pus in the urine; painful or frequent urination; kidney problems
- Diabetes or hypoglycemia (low blood sugar)
- Emotional or Mental health counseling or psychiatric treatment
- Rheumatism, gout, arthritis or other forms of swollen or painful joints
- Chronic back pain, back injury or surgery; sciatica, scoliosis or other bone or joint disorder
- Cysts, tumors or any growths, hernia or rupture

Yes No

- Cancer
- Fainting spells, dizziness, convulsions, epilepsy or seizure disorder
- High blood pressure, heart murmurs or other cardiac problems
- Vein or circulatory trouble
- Significant migraine headaches
- Goiter, thyroid ailment, high or low metabolism
- Anemia or other blood disorder
- Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders or venereal disease
- Parkinson's Disease
- Significant knee injury or problems
- Significant allergic reactions to either food, medicines, bee stings or any other insect bite or sting
- Any other diseases not listed above
- Any other serious bodily injuries, physical limitations or disabilities not listed above.

Please describe:

If you checked "yes" to any of the previous questions, your doctor must complete the Physician's Release at the bottom of the next page.

Guatemala 2010 Application

Medical Assessment

Are you currently using any non-prescription drugs on a regular basis? (If yes, please specify the medication and dosage.)

Yes No _____

Have you ever received treatment or counseling for alcohol or chemical abuse? (If yes, please specify when and where.)

Yes No _____

Are you presently under a physician's care? (If yes, please explain.)

Yes No _____

Do you have a condition that requires a special diet? (If yes, please explain.)

Yes No _____

Do you have any chronic or recurring health problems? (If yes, please explain)

Yes No _____

Do your grandparents, parents or siblings have any of the following: (If you answer "yes" to any of these, please explain who the person is and the severity of the problem.)

Yes No Diabetes

Yes No Depression

Yes No Hypertension

Yes No Mental Illness

Yes No Heart Disease

Examinations and Operations

What was the date and location of your last physical exam? _____

Who was the attending physician? _____

List all operations or hospitalizations you have undergone:

1. Date _____ Operation and reason _____

Attending physician _____ Name and location of hospital _____

Remaining effects _____

2. Date _____ Operation and reason _____

Attending physician _____ Name and location of hospital _____

Remaining effects _____

Please provide any details pertaining to your health not covered by the above questions. (If more space is needed attach a separate sheet of paper.) _____

In case of medical emergency, what doctor (knowledgeable about your health) should be contacted?

Doctor's Name _____ Phone _____

I certify that the information listed on this form is correct to the best of my knowledge. In case of emergency, I hereby authorize any necessary medical treatment by medical personnel.

Signature of Applicant _____ Date _____

PHYSICIAN'S RELEASE (This should be completed if any of the questions on page one were marked "yes.")

I have reviewed this applicant's medical information and history and this completed form and I have performed a physical exam on the applicant. I find him/her to be in a suitable condition for international travel, participation in high-intensity activities (such as hiking several miles) and conditions in a third-world country.

Physician's Signature _____ Date _____

