Application for Short-Term Missionaries

First Baptist Church

Date: _____

Legal name: _____

Social Security number _____

Age: _____ Birthday: _____/_____/_____

Address:_____City:_____

State: _____ Zip: _____ Phone #: _____

Cell phone #: _____ E-mail address: _____

T-shirt size ____Small _____Medium _____ Large _____ XX _____XXX

Church Membership: Where are you a member? _____ Baptised? _____ Yes _____No

Parent's/legal guardian's Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone #: _____ Work #: _____

Cell phone #: _____ E-mail address: _____

Emergency contact: Name: _____ Relation _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Work #: _____

Cell phone #: _____

RECORD OF CHILDHOOD IMMUNIZATIONS:

Tetanus □ Yes □ No Year_____

Polio □ Yes □ No Year_____

Diphtheria/Pertussis/Tetanus □ Yes □ No Year_____

Mumps/Measles/Rubella □ Yes □ No Year_____

Other_____ □ Yes □ No Year_____

MEDICAL CHECKLIST:

IF YOU HAVE ANY OF THE DISORDERS LISTED BELOW, YOU ARE ADVISED BUT NOT REQUIRED TO VISIT WITH YOUR DOCTOR. This information will be requested by the physician and medical facility in the event of an emergency. Please help us by making sure you give complete and correct information.

Yes	No		Yes	No	
☐	☐	AIDS Virus or HIV	☐	☐	Goiter
☐	☐	Chronic persistent cough	☐	☐	Skin disorder other than acne
☐	☐	Anemia or any other blood disorder	☐	☐	Diabetes or hypoglycemia
☐	☐	Depression or ADD or ADHD	☐	☐	Parkinson's disease
☐	☐	Circulatory trouble	☐	☐	Severe allergic reactions
☐	☐	Cancer	☐	☐	Cysts or tumors of any kind
☐	☐	Intestinal or bowel problems	☐	☐	Convulsions, epilepsy or seizures
☐	☐	Kidney problems	☐	☐	Serious bodily injury
☐	☐	Tuberculosis	☐	☐	Gall bladder stones or colic
☐	☐	Arthritis, painful swollen joints	☐	☐	Prostate problems
☐	☐	Chronic back pain	☐	☐	Asthma or chronic wheezing
☐	☐	Severe knee problems	☐	☐	Venereal disease
☐	☐	Mental health counseling/treatment			

MEDICAL INFORMATION

CURRENT MEDICAL CARE AND PRESCRIPTIONS:

• Do you have severe allergic reactions (ie. food, medicine, pollen, mold etc.) ? If so, to what? _____

_____

• Are you currently taking prescribed medication? Yes ___ No ___ If yes, please specify the medication and the dosage. _____

_____

• Are you currently using any non-prescription drugs on a regular basis, such as antihistamines or sleeping aids? Yes ___ No ___

If yes, please specify _____

_____

• Have you ever received treatment or counseling for alcohol or chemical abuse? Yes ___ No ___

If yes, please specify when and where _____

• Are you presently under a physician's care for any illness? Yes ___ No ___ Are you presently under a phychaitrist's care? Yes ___ No ___

If yes, please explain _____

_____

WHAT IS YOUR BLOOD TYPE? _____

PROOF OF DOMESTIC INSURANCE:

I certify that I have domestic health insurance that will cover me during the duration of the mission. I hereby understand that I am responsible for any medical expenses accumulated to the deductible or anything not covered by my domestic insurance or the trip policy.

_____	_____	_____ _____	_____
Company (must provide copy of medical insurance card)	Policy #	Insurance company	phone #

My Personal Testimony

First Baptist Church Short-Term Missions Preparation

Name: _____

Please write a paragraph that answers the questions below:

What was your life like before you met Jesus Christ?
(Your needs, how you became interested in God, etc.)

How did you come to know Jesus Christ as your Savior?
(Who were you with, When did this happen, What did you say to God?)

What is your life like with Christ now?
(What needs does Jesus meet? How is your faith different? How is your faith growing?)