

# HONDURAS MEDICAL MISSION TEAM APPLICATION

JUNE 11 – 18, 2008

## Mission Statement

*"To share God's healing message of love and forgiveness through the ministry of medicine."*

Our outreach to Corinto, Honduras, is rooted in our Christian faith. Worship services are planned throughout the mission. Everyone is invited to participate.

**Please print legibly.**

Date of Application \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home\_(\_\_\_\_) \_\_\_\_\_ Business\_(\_\_\_\_) \_\_\_\_\_ Cell\_(\_\_\_\_) \_\_\_\_\_

Fax\_(\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Name as it appears on Passport \_\_\_\_\_

Passport Number \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation or Related Work Experience \_\_\_\_\_

Do you speak Spanish? \_\_\_\_\_ If yes, how fluent? \_\_\_\_\_

If you have a Work Station preference, please check below:



Registration (computers)       Triage (blood pressure, weight)       Cook

Ophthalmology       Physician       Nurse Practitioner       Nurse

Veterinary       Pharmacy       Dental       Translator

Special Skills \_\_\_\_\_

ADDITIONAL COMMENTS \_\_\_\_\_

## HONDURAS MEDICAL MISSION EXPENSES – Per Participant (est. \$900)

DUE DATES	DATE RECEIVED	CHECK NO.	AMOUNT
\$100.00 Deposit due December 1, 2007			
50% of Balance due March 1, 2008			
Full Balance due May 1, 2008			
<i>Optional: Special Fund – Advanced Medical Care*</i>			

*\*Special account to fund advanced medical conditions in Corinto outside the boundaries of the mission team's abilities.*

The cost of the mission trip per participant will be approximately \$900.00 which includes airfare, lodging, and meals. The cost may vary according to the price of airfare taxes at the time of booking. To register for the mission, a deposit of \$100.00 is required with your signed, completed application packet. However, your deposit will be refunded if you cancel by the deadline or are not selected for this year's team.

We get group rates on our airline tickets. After we purchase the tickets, they are NON-REFUNDABLE. Tickets must be paid for by May 1. We cannot order your tickets unless you have PAID IN FULL. Thank you for your cooperation in this matter.

Licensed professionals (physicians, dentists, veterinarians, nurse practitioners, nurses, pharmacists, pharmacy technicians) MUST provide copies of their diplomas and licenses by March 1. If your license expires prior to the trip, please provide the renewal copies AS SOON AS POSSIBLE.

The deadline for turning in your *signed, completed* application packet with the \$100.00 deposit is December 1. Our pool for team member selection is dramatically increasing. Therefore, you must meet the deadline if you would like to be considered for selection.

When making payments to cover participant expenses, please include your name in the memo field *and* make your check(s) payable to: St. Mark's Honduras Medical Mission. This process will ensure that each payment will be credited to the appropriate participant. Please send your *signed, completed* application packet *with deposit and future payments to:*

*St. Mark's Episcopal Church Honduras Medical Mission  
ATTN: Treasurer  
2200 Avenue E  
Bay City, TX 77414*

Thank you for supporting this worthwhile mission which *"shares God's healing message of love and forgiveness through the ministry of medicine."*

Yours in Christ,

Reid Westmoreland  
2007-2008 Trip Director  
(979) 244-5697  
reidw56@yahoo.com

Christine Turner  
2007-2008 Trip Co-Director  
(281) 482-5195  
christina-t@sbcglobal.net

# **HONDURAS MEDICAL MISSION**

## **MEDICAL HISTORY FORM – Minor Participant**

Name of Minor Participant \_\_\_\_\_

Blood Type \_\_\_\_\_ Are you diabetic? \_\_\_\_\_ Do you have a history of seizures? \_\_\_\_\_

List all current medications: \_\_\_\_\_

\_\_\_\_\_

List any illnesses, physical limitations: \_\_\_\_\_

\_\_\_\_\_

List any surgeries: \_\_\_\_\_

\_\_\_\_\_

List any allergies/medications: \_\_\_\_\_

\_\_\_\_\_

List all immunizations: \_\_\_\_\_

\_\_\_\_\_

Other medical information not listed above: \_\_\_\_\_

\_\_\_\_\_

*In case of emergency, notify the following contacts. If the primary contact is on the mission, the alternate contact must NOT be on the mission AND must either be parent/legal guardian or have power of attorney.*

Primary Contact Name \_\_\_\_\_  
Relationship to Participant \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

*Alternate Contact*

Name \_\_\_\_\_  
Relationship to Participant \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

*Are you adequately healthy to fulfill your responsibilities on the voluntary mission team? Yes or No*

Signature of Minor Participant \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*Is your child adequately healthy to fulfill his/her responsibilities on the voluntary mission team? Yes or No*

Signature of Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Minor Participant \_\_\_\_\_

# HONDURAS MEDICAL MISSION

## MEDICAL AUTHORIZATION FORM – Minor Participant

I, \_\_\_\_\_, in the event of an emergency during the duration of the mission trip, hereby give consent to any necessary medical examination(s), medication(s), treatment(s), anesthesia, surgery, outpatient care and/or hospital care rendered to my child/ward, \_\_\_\_\_, under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state or country in which they practice, during the mission trip identified above.

I understand that I am responsible for my child's/ward's medical insurance and will not hold Honduras Medical Mission, Episcopal Diocese of Texas, St. Mark's-Bay City, the Episcopal Diocese of Honduras, and any of their affiliates liable for any injury or damage to me while engaged in the medical mission.

Participant's Physician \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

Insurance Company\_\_\_\_\_

Mailing Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_

Policy Number\_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

Signature of Minor Participant\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Signature of Parent/Legal Guardian\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Relationship to Minor Participant\_\_\_\_\_

Mailing Address of Parent/Legal Guardian\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_

Home\_(\_\_\_\_\_)\_\_\_\_\_ Business\_(\_\_\_\_\_)\_\_\_\_\_ Cell\_(\_\_\_\_\_)\_\_\_\_\_

Fax\_(\_\_\_\_\_)\_\_\_\_\_ Email\_\_\_\_\_

Dates covered by this Authorization Form: June 11, 2008 through June 18, 2008

Honduras, Central America  
San Pedro Sula, Honduras  
Corinto, Honduras

# HONDURAS MEDICAL MISSION

## LIABILITY RELEASE FORM – Minor Participant

*Please read before signing, as this constitutes the agreement as a volunteer and the understanding of your working relationship as a volunteer with Honduras Medical Mission.*

I, \_\_\_\_\_ parent/legal guardian of my child/ward \_\_\_\_\_ acknowledge and state the following:

My child/ward has chosen to travel to perform medical mission work in Honduras, Central America. I certify that my child/ward is in good health and physically able to perform this type of work.

I understand that my child/ward is engaging in this project at his/her own risk. I assume all risk and responsibility for any damage or injury to his/her property or any personal injury, which my child/ward may sustain while involved in this project, and related medical costs and expenses.

I understand that Honduras Medical Mission (HMM) is not responsible or liable for my child's/ward's personal effects and property and that lock up or security for any personal items will not be provided. I will hold HMM harmless in the event of theft or for loss resulting from any source or cause.

I understand that personal trips, excursions, and activities outside the scope of the mission work are NOT allowed.

I further understand that my child/ward is to abide by whatever rules and regulations may be in effect for the accommodations at that time.

By my signature, for myself, for my child/ward, for my estate and my heirs, I release, discharge, indemnify and forever hold Honduras Medical Mission, Episcopal Diocese of Texas, St. Mark's-Bay City, the Episcopal Diocese of Honduras, and any of their affiliates together with their officers, agents, servants, and employees, harmless from any and all causes of action arising from my child's/ward's participation in this project, and travel or lodging associated therewith, including any damages which may be caused by their negligence.

Signature of Minor Participant \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Parent/Legal Guardian \_\_\_\_\_

Mailing Address of Parent/Legal Guardian \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home\_(\_\_\_\_\_) \_\_\_\_\_ Business\_(\_\_\_\_\_) \_\_\_\_\_ Cell\_(\_\_\_\_\_) \_\_\_\_\_

Fax\_(\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Dates of work covered by this liability form: June 11, 2008 through June 18, 2008

Honduras, Central America  
San Pedro Sula, Honduras  
Corinto, Honduras