

# Eagle's Nest

Customized Mission Treks  
www.missiontreks.com



- Fill in application information below.
- Include a recent photo of each leader.
- Include the non-refundable \$100 team registration fee. Make check out to Eagle's Nest Mission Treks, Inc.
- Give one individual application and release form to each team member (make copies of the original in this packet) and have the team members return them to you. All the paperwork is to accompany you, the leader, to Mexico. **Please note that a notarized letter signed by both parents is required for a minor to leave the country!**
- Mail: Team Leader's Application form, registration fee, and photo of the team leader(s) to the address at the bottom of this page. Make sure all forms are signed.

Outreach dates: \_\_\_\_\_

## Group Info...

Group Name: \_\_\_\_\_ Senior Pastor: \_\_\_\_\_

Church name & address: \_\_\_\_\_

\*Total number of participants: (male) \_\_\_\_\_ (female) \_\_\_\_\_ \*Total number of adult leaders: \_\_\_\_\_

\*If you are not sure of the exact number, make as accurate a projection as possible.

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## Team Leader Info...

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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## Assistant team leader info...

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

# Some questions for the leader...

1. Describe your team

2. What are your goals for this outreach?

3. Do you have any special needs as a group?

4. Do you have any special talents or gifts on the team?

5. What types of ministry would you like to engage in? (Please list in order of priority)

6. Can you bring Bibles or tracts in Spanish? Other ministry tools? Instruments or leaders for worship sessions?

7. Are there any specific skills you can employ in work projects?

Name:	Age:	Sex:	T-shirt size:
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2.			
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24.			

# Eagle's Nest

*Customized Mission Treks*



## MISSION TRIP APPLICATION

(Please print)

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

First Middle Last

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Citizenship \_\_\_\_\_ Passport # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Church Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Pastor's Name \_\_\_\_\_

## SPECIAL INFORMATION

Will children accompany you (list age and sex of each child)? \_\_\_\_\_

How long have you been attending the above- listed church? \_\_\_\_\_

How long have you been in a personal relationship with Jesus Christ? \_\_\_\_\_

Please indicate any special talents/skills. \_\_\_\_\_

Do you have any previous missions experience? (If so, when & where?) \_\_\_\_\_

## IN CASE OF EMERGENCY CONTACT:

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**WHAT WOULD YOU LIKE TO SEE GOD DO IN YOU AND THROUGH YOU ON THIS MISSION TRIP? EXPLAIN BELOW:**

# CONFIDENTIAL HEALTH FORM

Name \_\_\_\_\_ Applying For \_\_\_\_\_

In an emergency, contact: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Ins. # \_\_\_\_\_

**Personal History:** Please answer all questions. Explain any 'YES' answers in the space below.

HAVE YOU EVER HAD, OR DO YOU HAVE, ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Skin Conditions	<input type="radio"/>	<input type="radio"/>	Shortness of Breath	<input type="radio"/>	<input type="radio"/>	Stomach/ duodenal ulcer	<input type="radio"/>	<input type="radio"/>
Eye Trouble	<input type="radio"/>	<input type="radio"/>	Hay fever, asthma	<input type="radio"/>	<input type="radio"/>	Gall Bladder Problems	<input type="radio"/>	<input type="radio"/>
Ear Trouble	<input type="radio"/>	<input type="radio"/>	Heart trouble	<input type="radio"/>	<input type="radio"/>	Jaundice	<input type="radio"/>	<input type="radio"/>
Head Injury	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
Recurrent Headache	<input type="radio"/>	<input type="radio"/>	Low Blood Pressure	<input type="radio"/>	<input type="radio"/>	Intestinal Troubles	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	Rheumatism/Arthritis	<input type="radio"/>	<input type="radio"/>	Recurrent Diarrhea	<input type="radio"/>	<input type="radio"/>
Fainting Spells	<input type="radio"/>	<input type="radio"/>	Back Problems	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>
Mental Disorders	<input type="radio"/>	<input type="radio"/>	Dislocation of joints	<input type="radio"/>	<input type="radio"/>	Kidney disease	<input type="radio"/>	<input type="radio"/>
Weakness	<input type="radio"/>	<input type="radio"/>	Broken Bones	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>
Paralysis	<input type="radio"/>	<input type="radio"/>	Eating Disorders	<input type="radio"/>	<input type="radio"/>	Venereal disease	<input type="radio"/>	<input type="radio"/>
Insomnia	<input type="radio"/>	<input type="radio"/>	Anorexia Nervosa	<input type="radio"/>	<input type="radio"/>	Tumor; Cancer	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	Bulimia	<input type="radio"/>	<input type="radio"/>	<b>FEMALES ONLY</b>		
Penicillin	<input type="radio"/>	<input type="radio"/>	Surgery	<input type="radio"/>	<input type="radio"/>	Irregular periods	<input type="radio"/>	<input type="radio"/>
Sulfonamides	<input type="radio"/>	<input type="radio"/>	Appendectomy	<input type="radio"/>	<input type="radio"/>	Severe Cramps	<input type="radio"/>	<input type="radio"/>
Serum	<input type="radio"/>	<input type="radio"/>	Hernia Repair	<input type="radio"/>	<input type="radio"/>	Excessive Flow	<input type="radio"/>	<input type="radio"/>
Other- (Specify)	<input type="radio"/>	<input type="radio"/>	Tonsillectomy	<input type="radio"/>	<input type="radio"/>	Are You Pregnant?	<input type="radio"/>	<input type="radio"/>
Food- (Specify)	<input type="radio"/>	<input type="radio"/>	Others (specify)	<input type="radio"/>	<input type="radio"/>	Previous Pregnancies	<input type="radio"/>	<input type="radio"/>

Other/Explain \_\_\_\_\_

Are you now under a doctor's care for any condition?  YES  NO (specify) \_\_\_\_\_

Are you taking any medication at this time?  YES  NO (specify) \_\_\_\_\_

Do you have any physical handicaps or health conditions that require special attention?  YES  NO  
(specify) \_\_\_\_\_

Do you have a history of counseling or psychiatric treatment?  Yes  No (specify) \_\_\_\_\_

Are you  overweight?  underweight? Pounds over/under \_\_\_\_\_ Blood Type \_\_\_\_\_

Would you rate your health condition as:  Excellent  Good  Fair  Poor

**FAMILY HISTORY-** Have any of your relatives ever had any of the following?

Yes	No	Relationship	Yes	No	Relationship
<input type="radio"/>	<input type="radio"/>	Tuberculosis _____	<input type="radio"/>	<input type="radio"/>	Arthritis _____
<input type="radio"/>	<input type="radio"/>	Diabetes _____	<input type="radio"/>	<input type="radio"/>	Stomach Problems _____
<input type="radio"/>	<input type="radio"/>	Kidney Disease _____	<input type="radio"/>	<input type="radio"/>	Asthma, hay fever _____
<input type="radio"/>	<input type="radio"/>	Heart Disease _____	<input type="radio"/>	<input type="radio"/>	Convulsions, Epilepsy _____
<input type="radio"/>	<input type="radio"/>	Hypertension _____	<input type="radio"/>	<input type="radio"/>	Cancer _____

Have you ever had any of the following **COMMUNICABLE DISEASES**?

Yes	No		Yes	No	
<input type="radio"/>	<input type="radio"/>	Chickenpox	<input type="radio"/>	<input type="radio"/>	Pertussis
<input type="radio"/>	<input type="radio"/>	Measles (Rubella)	<input type="radio"/>	<input type="radio"/>	Scarlet Fever
<input type="radio"/>	<input type="radio"/>	Measles (Rubeola)	<input type="radio"/>	<input type="radio"/>	Tuberculosis
<input type="radio"/>	<input type="radio"/>	Mumps	<input type="radio"/>	<input type="radio"/>	Other (specify) _____

**TO THE PHYSICIAN**

Name of Applicant \_\_\_\_\_

The above-named person has applied for an overseas missions trip. This program will require good health and endurance. Please review the 'Personal History' information on the opposite side, fill out the portion below, and make any additional comments. Thank you.

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Are there any abnormalities of the following systems?

	Yes	No	Please Describe
Ear, Nose, Throat	<input type="radio"/>	<input type="radio"/>	_____
Eyes	<input type="radio"/>	<input type="radio"/>	_____
Neurological	<input type="radio"/>	<input type="radio"/>	_____
Cardiovascular	<input type="radio"/>	<input type="radio"/>	_____
Respiratory	<input type="radio"/>	<input type="radio"/>	_____
Musculoskeletal	<input type="radio"/>	<input type="radio"/>	_____

Would he/she be able to walk 3-4 miles per day?    Yes    No

Comments: \_\_\_\_\_

**PHYSICIAN RECOMMENDATION**

Acceptable without limitations

Should remain in areas where adequate medical care is provided

Not Acceptable

Acceptable with limitations (specify) \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Name (printed) \_\_\_\_\_

Full Address \_\_\_\_\_

# Notarized Consent Forms

## CONSENT FOR TREATMENT

I/We hereby agree to the performance of such treatment, anesthetics, and operations as in the opinion of the attending physician is deemed necessary on the above named person.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Parent / Guardian Signature (if applicant is under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date / Relationship to Applicant

\_\_\_\_\_  
Signature and seal of Notary Public

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## LIABILITY RELEASE

I/We hereby release EAGLE'S NEST, its agents, employees, and volunteer assistants from any liability whatsoever arising out of an injury, damage, or loss which may be sustained by said person(s) during the course of involvement with EAGLE'S NEST.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Parent / Guardian signature (if applicant is under 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date / Relationship to Applicant

\_\_\_\_\_  
Signature and seal of Notary Public

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## LEGAL CONSENT FOR MINORS

I hereby give my consent for \_\_\_\_\_  
(Complete Name of Minor)  
to travel outside of the United States of America with EAGLE'S NEST.

Signature of Parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature and seal of Notary Public