**Contact & Medical INFORMATION**

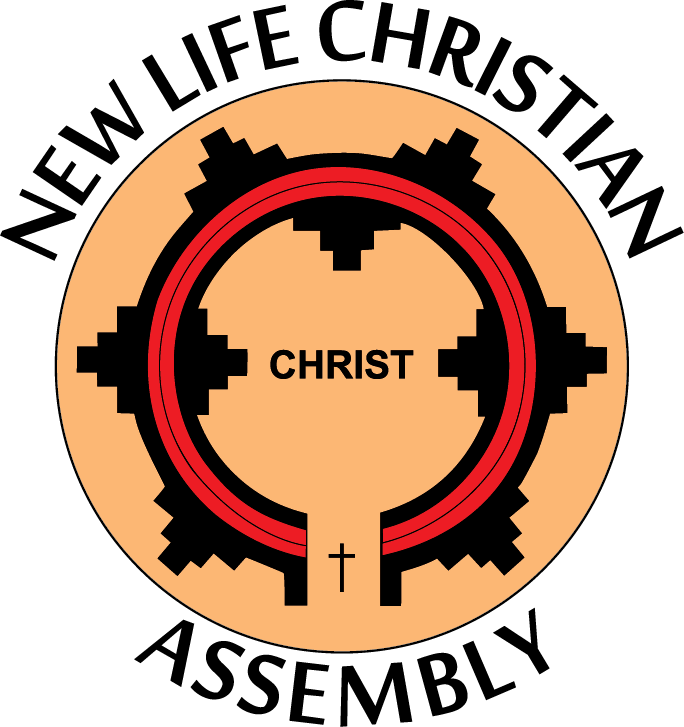
Send form to:

New Life Christian Assembly

P.O. Box 547

Church Rock, NM 87311-0547

**Please review and fill out the form below.**



Trip Dates:

Full Name – First: MI: Last:

Home Address:

City: ST: ZIP:

Home Phone: ( ) - Cell Phone: ( ) -

Email Address: D.O.B. / /\_

**HEALTH INSURANCE: Each participant is responsible for medical expenses.**

# Insurance Co.: Policy #:

Insurance Co. Street Address:

City: ST: ZIP:

Physician’s Name: Phone # ( ) -

Emergency Contact: Relationship: Phone:( ) -

MEDICAL INFORMATION: Allergies (including medicines, foods, bites, stings etc. 🞐 NONE

|  |  |  |
| --- | --- | --- |
| Allergy: | Reactions: | Medication Required: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

MEDICAL INFORMATION: Medication: List all current medications below. 🞐 NONE

|  |  |  |  |
| --- | --- | --- | --- |
| Medication: | Condition: | Dosage (size/frequency) | Current Side Effects |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
|  |  |  |  |

# **Liability release**

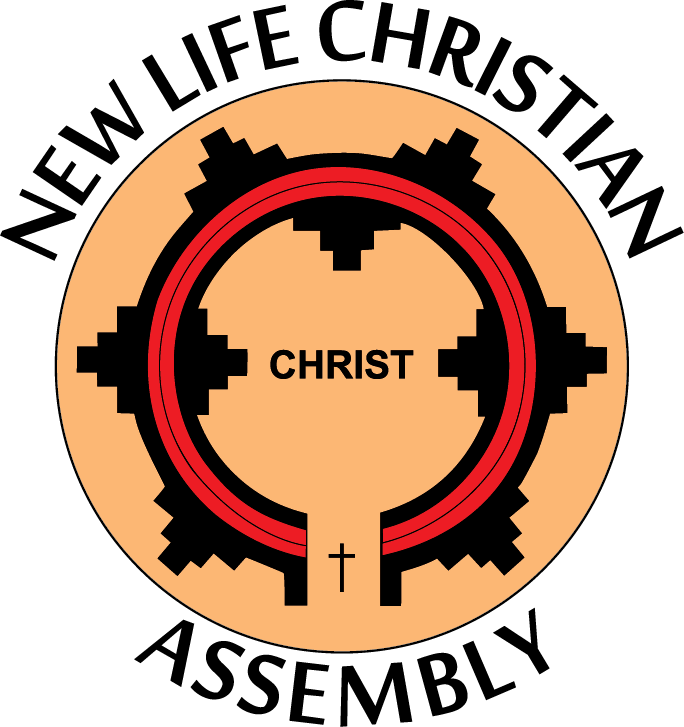
Send **original notarized** form to:

New Life Christian Assembly

P.O. Box 547

Church Rock, NM 87311-0547.

**Please review and fill out the form below.**



I understand that New Life Christian Assembly with whom I am serving on my mission trip is a ministry organization and that I must raise my own support, or pay directly, for airline fare, room and board, personal items, spending money, and any other costs that might arise during my trip.

I am aware that I could encounter health or safety risks during the trip. I understand that Pine Dale, NM is located at an elevation of 7,000 ft. To the best of my knowledge, my health is good enough to undertake the trip and I have no known conditions that would hinder my performance of my volunteer duties on the trip.

I understand the risks inherent in a mission trip and I voluntarily and knowingly assume those risks and acknowledge that, in releasing and waiving all claims, demands, actions, or causes of action as follows in this agreement, I do so on behalf of myself, my heirs, executors, administrators, successors, and assigns.

I agree not to hold New Life Christian Assembly or its representative responsible for items stolen or lost while on the trip.

I give permission for New Life Christian Assembly to use group or individual photos or video in any publication promoting New Life Christian Assembly and Mission Based Adventure Travels (MBAT).

I authorize New Life Christian Assembly to provide or furnish any necessary transportation, food, or lodging associated with the mission trip. Further, I acknowledge my status and capacity as a licensee only with respect to any real property used or occupied in conjunction with the mission trip and, by signing this agreement, I release and discharge the owner and occupier of the real property from any and all liability, claims, demands, controversies, damages, actions, and causes of action arising out of the use or occupation of the real property.

I agree to indemnify and save harmless New Life Christian Assembly, their employers, employees, principals, agents, insurers, successors, and assigns from any liability incurred by them resulting from my negligent, willful, wanton, or intentional acts.

In consideration of my acceptance to participate in the Mission Based Adventure Travel trip, I forever release and discharge New Life Christian Assembly, their employers, employees, principals, agents, insurers, successors, and assigns for and from any and all liability, claims, demands, controversies, damages, actions, and causes of action arising out of, or resulting from my participation in the MBAT, including but not limited to all liability, claims, or demands for my personal injury, sickness, or death, as well as property damage and expenses arising out of, directly or indirectly, the MBAT mission trip.

I give permission for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary.

All information will remain confidential. You should know that over the years, many participants with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants.

I have read and understand this agreement.

|  |  |
| --- | --- |
| Name of Participant (please print): | Signature of Participant (must be signed in the Notary’s presence): |
| Name of Parent or Guardian if Participant is Under the Age of 18: | Signature of Parent or Guardian: |
| Notary: | My Commission Expires: |
| Date: / / | SEAL: |