

Leroy Chapel Short Term Mission Trip Profile

Date Submitted

Mission Profile

Mission Organization Trip Destination Trip Date
 Trip Information

Personal Profile

Name Date of birth
 Home street address Email
 City State ZIP
 Home phone Cell Work
 Emergency contact Cell Home

References (please provide at least two non-family members)

Name	Relationship	Home Phone	Cell	Email Address
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Medical Profile

Are you currently receiving medical treatment or evaluation on a regular basis? Yes No

If yes, please detail:

Are you currently taking medication(s)? Yes No

If yes, please detail:

Have you ever had, or have you now, any of the following conditions? If yes, please explain on a separate sheet.

	Yes	No		Yes	No		Yes	No
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Visual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High/low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Back or Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Digestion Problems	<input type="checkbox"/>	<input type="checkbox"/>
Mental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Foot or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>

Blood type

Family physician Phone

Experience & Abilities Profile

Have you been on a mission trip before? If yes, where and when?

Please give a brief explanation for your motivation - why do you want to go and what would you like to get out of this trip?

What areas of work are you interested in and gifted for?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Public speaking | <input type="checkbox"/> Teaching | <input type="checkbox"/> Finish Carpentry | <input type="checkbox"/> Plumbing |
| <input type="checkbox"/> Preaching | <input type="checkbox"/> Youth leadership | <input type="checkbox"/> Framing | <input type="checkbox"/> Hanging Drywall |
| <input type="checkbox"/> Personal Evangelism | <input type="checkbox"/> News writing | <input type="checkbox"/> Hanging Doors/Windows | <input type="checkbox"/> Roofing |
| <input type="checkbox"/> Music Performance/Worship | <input type="checkbox"/> Photography | <input type="checkbox"/> HVAC | <input type="checkbox"/> Electrical |

Other

Anything else you'd like us to know about you before going on this trip?

I understand that any mission trip includes an inherent level of explicit and implicit risk. Travel accidents, sickness, and injuries are among these risks. I knowingly accept the risks of participating in this mission trip.

Signature (parent or guardian, if a minor)

Date