Kentucky District Pathfinder's Mission Trip Application Packet

Life Bridge Inner City Missions
Savannah, Georgia
June 1 – June 7, 2009
Mission Trip Fee $400.00 per person

LAST NAME FIRST NAME DATE OF BIRTH

MO DAY YEAR

MAILING ADDRESS

AREA CODE + PHONE NUMBER

CITY STATE ZIP OUTPOST NUMBER

CHURCH NAME

I am personally acquainted with the applicant and, in my opinion he is a competent and qualified youth worker/standing member of our church.

Pastor's Signature_____ **Date:** _____

REQUIREMENTS

Age 14-15 must have parent along with forms, age 16-17 must have written permission with forms and everyone needs to be in good health in order to participate in the strenuous activities of the mission trip. All forms must be filled out each individual attending.

Pre- Registration is $100.00 and is due by **February 28, 2009** the balance of $300.00 is due by **May 1, 2009**. All forms must accompany the balance in order to attend the trip.

Make your check payable to: **Kentucky District Royal Rangers**
Mail your application and medical form to:

Frankie Harris
District Missions Coordinator
3309 Rt. 121 N
Mayfield, Ky. 42066

FOR OFFICE USE
POSTMARKED:

PAID:

BAL. DUE:

ASSUMPTION OF RISK AND INSURANCE ELECTION

Mission America Placement Service
MAPS Team Member

PART 1 – Assumption of Risk

I, _____ (name of volunteer), in consideration of my acceptance as a short-term volunteer with the Mission America Placement Service (MAPS) of the Assemblies of God U.S. Missions of the General Council of the Assemblies of God, USA, represent and agree that:

1. I am a volunteer worker and acknowledge that I am not an employee of MAPS, the Assemblies of God U.S. Missions, or the General Council of the Assemblies of God, USA.

2. I am aware of the hazards and risks to my person and property associated with serving in a missions capacity, such hazards and risks including, but not being limited to, death or injury by accident, disease, terrorist acts, weather conditions, inadequate medical services and supplies, criminal activity, and random acts of violence. I accept my assignment with full awareness of these risks, and subject to the insurance coverages described below, I voluntarily assume all risks of death, injury, illness and damage to myself or any members of my family associated with such risks, or any damage to my personal property. I further recognize that such risks have always been associated with missionary service. *(2 Corinthians 11:23-28)*

3. I attest and certify that I have no medical condition that would prevent me from performing my duties.

4. Subject to insurance coverages described below, I waive any and all claims for damages which I , or my heirs or successors, may have against MAPS, the Assemblies of God U.S. Missions, the General Council of the Assemblies of God, and District Council of the Assemblies of God, the local church/individuals sponsoring the MAPS trip/assignment, or any agent, employee or member of any such organization, arising from my death, injury, or illness, or any property damage or loss occurring during the term of my assignment or as a result of my assignment.

5. In the event that I have minor children who will accompany me on my assignment, I, acting both on my own behalf and in their behalf as their parent or legal guardian, and subject to the insurance coverages described below, do hereby assume all risks of death, illness, or injury that they may suffer as a result of said assignment, from those causes described above.

6. I understand and accept the following policy of the Assemblies of God U.S. Missions regarding ransom payments:

> The U.S. Missions Board has determined that it will not pay ransom nor yield to the demands of anyone who takes hostage one of our missionary family or staff hostage. The Assemblies of God U.S. Missions pledges itself to every effort in prayer and all other appropriate means to obtain the release of one taken hostage should it ever occur. This policy was made after sufficient study of the policies of other evangelical missionary societies and after considering advice of the United States State Department.

7. I expressly waive any defense to the enforcement of any provisions of this commitment arising from a claim of lack of consideration and warrant that this commitment constitutes a legal, valid, and binding obligation upon me enforceable against me in accordance with its terms.

8 I expressly agree that this assumption of risk and indemnity agreement is intended to be as broad and inclusive as permitted by law. **I FURTHER STATE THAT I HAVE CAREFULLY READ THE FOREGOING ASSUMPTION OF RISK AND UNDERSTAND ITS CONTENTS, AND I VOLUNTARILY SIGN THIS RELEASE AS MY OWN FREE ACT.**

PART 2 – Insurance Election

I am aware of the hazards and risks to my person associated with serving in a missions capacity, as described above. I further understand that MAPS currently offers the insurance coverages summarized below, that I am responsible for the cost of such insurance, that these coverages are subject to change, and that I am responsible for obtaining any additional insurance coverage that I consider necessary:

* $100,000	24-hour accidental death and dismemberment
* $ 1,000	Monthly limit for permanent total disability based on an accident (88-month maximum, with a 12- month waiting period). A lump sum payment of $12,000.
* $250	Monthly limit for permanent total disability based on illness (50 month maximum, with a 3-month waiting period).
* $50,000	Accident medical limit.
* $10,000	Sickness medical limit.
* $50	Deductible per occurrence.
* $75,000	Medical air taxi limit

Please check the appropriate statement:

_____I have adequate insurance coverage and do not desire the insurance coverage described above.

_____I desire the above-described insurance coverage with Guarantee Trust Life Insurance Company

SIGNATURES

Date: _____

_____ _____

Legible Signature Legible Signature of Spouse (if he/she will accompany you on this trip)

Address City State Zip

IMPORTANT: ***Please have two (2) witnesses observe your signing of this form, and have the witnesses sign below. They must be at least 18 years old, and they cannot be your relatives.***

_____ _____

Witness' legible signature Address

_____ _____

Witness' legible signature Address

Team Trip Information:

Name of Church: _____ City, State: _____

Destination: _____

Date of Departure: _____ Date of Return: _____

Please send the signed Assumption of Risk form to this address prior to your trip:

Frankie Harris
3309 Rt. 121 N.
Mayfield, Ky. 42066

Guarantee Trust Life Insurance Company

Beneficiary Designation

Insured's Name *(print)* _____
Last *First* *Middle Initial*

Start Date of Travel _____
Month *Day* *Year*

Beneficiary _____

Beneficiary's Relationship to Insured _____

Policyholder: Assemblies of God

Policy Number: 246-018-001 S

Signature of Insured _____

Date of Signing _____

**Note: one form required for each insured individual*

Code of Conduct

Please place your initials by each statement below:

As a MAPS team member I realize the important role I play as an example to those in the United States and abroad. I understand that I represent not only my local church, but also the MAPS Department, the Assemblies of God U.S. Missions, the General Council of the Assemblies of God, and the United States as a whole.

I understand the Assemblies of God official statement of abstinence from alcohol, tobacco, and controlled substance use and/or abuse. In respect to God, the Assemblies of God, its missionaries, pastors, and the national church that I will be ministering to, I will refrain from:

_____ The purchase and/or use of *any* kind of alcoholic beverage

_____ The purchase and/or use of *any* tobacco products

_____ The purchase and/or use of *any* other controlled substance
(Does not include the use of personal medications, as prescribed by a doctor, or the use of necessary over-the-counter medications such as Aspirin, Tylenol, Pepto-Bismol, etc.)

I _____, have read and understood the above policy. I promise to forego my personal convictions on the subject in order to maintain unity and to avoid controversy in the body of Christ.

Signed: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

MEDICAL RECORD FORM
KENTUCKY DISTRICT ROYAL RANGER ACTIVITIES

Part 1: HEALTH HISTORY

A physical examination (minimum of **SPORTS EXAM**), signed by a medical practitioner, is strongly recommended for participation in a Royal Ranger activity. We recommend that this entire form be completed and mailed with the application. However, persons without a medical record form, signed by a health practitioner, will be required to sign an **ASSUMPTION OF RISK FORM** at the activity. The Kentucky Royal Rangers Ministries office has the prerogative to accept or reject any applicant based upon their medical health.

HEALTH HISTORY	Answer **YES** or **NO** to the following and briefly explain all **YES** answers under **REMARKS**.		
Sinus Condition?		Food Allergies?	
Lung Problems?		Do you wear contacts?	
High Blood Pressure?		Medical Care within the past year?	
Allergies/Asthma?		Surgery within the past year?	
Fainting/Dizziness?		Taking prescription medication?	
Shortness of Breath?		Any reaction to drugs or medication of any type?	
Skin Infections?		Exposure to infectious disease within the past 3 weeks?	
Hearing Difficulties?		Exposure to Hepatitis within the past 6 months?	
Vision Problems?			

REMARKS AND MEDICAL FACTS WE SHOULD KNOW IN CASE OF EMERGENCY:

VACCINATIONS	**TETANUS**	**SMALL POX**	**MEASLES**	**TYPHOID**	**DIPHTHERIA**	**POLIO**
DATE GIVEN ➔						

I know of no physical reason that would restrict me from participation in camp activities.

Applicant's Signature: _____ Date: _____

Part 2: PHYSICAL EXAMINATION

Print Applicant's Name:	**Examination Date:**	**Birth Date:**	**Height:**	**Weight:**	**Occupation:**

BRIEFLY INDICATE CONDITION	**HEART**	**LUNGS**	**THROAT**	**BLOOD PRESSURE**
	EYES	**SKIN**	**EARS**	**HERNIA?**

Physician Please Note:
Persons enrolled in outdoor activities are exposed to strenuous physical activity. Therefore, the applicant must be physically sound and strong enough to engage in such activity. In your opinion, is the applicant capable of strenuous activity? YES _____ NO _____
REMARKS:

Health Practitioner's Name: (Please Print.)	Business Address:
Health Practitioner's Signature:	Business Telephone Number: