

# Youth Registration for Mexico Mission 2010

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

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

Nickname: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Age on 6/19/10: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Birth date: \_\_\_\_\_

Gender:  Male  Female

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

T-shirt Size: S M L XL 2XL 3XL

Speak Spanish:  Fluent  Some  None

Vegetarian:  Yes  No

Food Allergies:  Yes  No

List any food  
allergies:

\_\_\_\_\_

Church: \_\_\_\_\_

City: \_\_\_\_\_

Pastor: \_\_\_\_\_

Church Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Contact Number: \_\_\_\_\_

2<sup>nd</sup> Emergency  
Contact: \_\_\_\_\_

Contact Number: \_\_\_\_\_

## This section to be completed by Parent/Guardian:

I give my consent for \_\_\_\_\_ to attend and participate fully in Mexico Mission. I have read the mission covenant, and I understand that if my child violates the covenant, I will be responsible for his/her early transportation home.

\_\_\_\_\_  
Parent/Guardian Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Printed Name:

## This section to be completed by Youth:

I, \_\_\_\_\_, have read the Mission Covenant, and agree to abide by the Covenant. I understand that if I violate the covenant, I will be sent home early at my parents/guardians expense.

\_\_\_\_\_  
Youth Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Printed Name:

### Total cost for trip: \$700

Registration forms are due by April 18<sup>th</sup>. All registrations must include a \$150.00 deposit (\$100 non-refundable). The balance must be paid no later than May 15th. All payments are to be made payable to First Christian Church – Mexico Mission 2010.

Please send completed registration forms (pages 1-4) with deposit to:  
First Christian Church – Mexico Mission 2010, 3039 Willow Pass Road, Concord, California 94519.

# Mission Covenant

While on this mission trip all youth and adults agree to live by the covenant:

**In order to help create an environment in which faith may be deepened and Christian community experienced ...**

**I agree to be authentic ...**

by setting an example of a Christian life style.

I will not use offensive language.

I will not engage in disrespectful, abusive or violent behavior toward others.

I will respect the people of Mexico and their culture.

I will not bring or purchase weapons.

I will not enter any tent other than my own.

**I agree to take care of myself...**

I will not bring or use alcohol or illegal drugs.

I will not bring or use tobacco products.

I will hydrate my body.

I will not engage in sexual behavior.

I will not wander off alone.

I will follow all safety procedures and guidelines.

**I agree to be physically and emotionally "present"...**

by participating in all of Mexico Mission including:  
fundraisers, community building event, campfire, worship,  
working to set up camp, build a house, help out in the kitchen or whatever is asked.

**I agree to help make this Mission the best it can be...**

I will not bring valuables or electronic equipment, including iPods, games, etc.

I will use the phone only in case of emergency and with permission of the director(s).

**I agree to be part of the "team"...**

by pulling my share of the load.

**I agree to be "human"...**

by being able to acknowledge my mistakes and accept the consequences;

by knowing my limits and accepting help.

I will try to learn from others and allow others

to learn from each other and from me.

**I agree to be clear, open and honest in my communication...**

If I am not feeling well, I will ask for help.

I will be kind with my words and actions.

**I agree to model safe touch and appropriate behavior...**

with everyone. When I am in doubt about appropriateness of behavior,

I will seek the counsel of the director(s) or Spiritual Leader.

**I agree to act responsibly...**

By adhering to all of the guidelines listed above.

I will treat everyone with respect.

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Signature

# Youth Medical Form for Mexico Mission 2010

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_

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

Age: \_\_\_\_\_

Gender:  Male  Female

Birth date: \_\_\_\_\_

The following information is required to ensure that your child's individual needs are met. Information is confidential and will be made available only to those people who are directly responsible for your child's well being. In the event of an emergency, every effort will be made to contact the parent/guardian. No person will be allowed to attend Mexico Mission without a completed and signed copy of this form.

**MEDICAL HISTORY:** Has your child been subject to any of the following? Please check all that apply.

	In past year	More than 1 year ago		In past year	More than 1 year ago
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Tires easily	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Eye/ear problems	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	Muscle sprains	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>			

Does your child have any allergies? \_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_

Date of last DPT booster: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Insurance Policy / Member #: \_\_\_\_\_

Is your child currently under the care of a physician or Counselor? If yes, please give additional information. \_\_\_\_\_

Is there additional information, which would be of help in promoting your child's welfare while in Mexico? \_\_\_\_\_

Are there activities your child should not participate in while in Mexico? If so, please explain. \_\_\_\_\_

**As-needed Medications**

If you **do not** wish to have your child treated using the following medications in the event of the presence of the symptoms indicated, please check the “No” column. If the treatment listed below is acceptable for the corresponding symptoms, (**do not send the listed medication**) these non-prescription drugs will be provided. (Generic brands may be substituted for name brands listed here.)

Symptoms	Treatment	NO	Symptoms	Treatment	NO
Upper Abdominal Pain	Liquid Maalox		Fever, Flu; Headache	Ibuprofen, Acetaminophen	
Nausea	Maalox		Menstrual Cramps	Ibuprofen, Acetaminophen	
Allergy, Hives, Bites	Chlortrimatron, Benadryl		Muscle Spasm	Ibuprofen	
Acute respiratory reaction to insect bites	Adrenaline		Poison	Ipecac or Charcoal <b>Doctor will be called first</b>	
Constipation	Milk of Magnesia		Rash	Cortaid Cream	
Cough	Robitussin DM		Sinusitis	Sinutab	
Cuts	HibacLens and Polysporin		Sore Throat	Throat Lozenge, Acetaminophen	
Diarrhea	Imodium AD		Sunburn	Solarcaine (if not allergic to -caines) & Ibuprofen	
Earache	Auralgan (if not allergic to -caines), Sinutab, Afrin		Vomiting	Pedialite	
Eye Irritation	Visine AC				

**Medications:** Please list amount and times for each medication that your child takes on a regular basis. This information can be updated at any time or when your child arrives at registration. All medications must be in their original packaging and will be administered by the Nurse during mission. All medicines, including vitamins, must be turned over to the Nurse.

Medication	Dosage	Interval	Purpose

**Medical Release Statement (MUST be signed)**

**My Child,** \_\_\_\_\_ **is in good health.** I will notify the director if my child is exposed to any communicable disease during the two weeks prior to attending Mexico Mission.

**In case of medical emergency,** I give my permission to the physician selected by the Director, Nurse, or other authorized to secure proper treatment for, hospitalize and order injection, anesthesia or surgery for my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Office Phone

\_\_\_\_\_  
Cellular Phone