



GLOBAL IMPACT TEAM 2019 APPLICATION

**Please complete a separate application for each individual

This application is in 3 parts. All parts (part 3-consent form, only if applicable) must be completed before application can be processed and must be accompanied by the \$400 non-refundable deposit.

Should your application be denied for any reason, your deposit will be refunded to you.

PART I

1. Personal Information

*First/Middle/Last Name _____

Best Telephone contact _____ [] cell [] work [] home

Street _____

City _____ State _____ Zip _____

Email Address _____

Emergency Contact Person _____

Relationship _____ Phone _____ Email _____

2. Participation Information - Please indicate which team(s) in which you are interested in participating:

- | | | |
|--|--|---|
| <input type="checkbox"/> Medical Project/Sports Camp Cedeño/San Juan Pueblo, Honduras March 28 – April 6, 2019 \$1800.00 <i>Application due 1/1/19</i> | <input type="checkbox"/> Convoy of Hope Dover, DE July 11 – 13, 2019 \$200.00 <i>Application due 5/15/19</i> | <input type="checkbox"/> Medical Project Skhoder, Albania August 15 - 23, 2019 \$2300.00 <i>Application due 4/15/19</i> |
| <input type="checkbox"/> Sports Camp Cuba August 23 – 31, 2019 \$1250.00 <i>Application due 3/1/19</i> | <input type="checkbox"/> Medical Project/Sports Camp Lagos, Nigeria October 2 – 12, 2019 \$2400.00 <i>Application due 3/1/2019</i> | <input type="checkbox"/> Social Compassion Port Salut, Haiti October 5 – 12, 2019 \$1550.00 <i>Application due 6/1/19</i> |

Please state your purpose and desires for participating in this particular outreach:

Indicate what specific skills set you think would enable you to serve effectively on this particular team:

3. Travel Information (Please answer all questions) - INTERNATIONAL OUTREACHES ONLY

Passport Number *(for international projects only)* _____

Expiration date _____ Country of Issue _____

I am over 18 years of age? Yes No
(If not, a completed consent form signed by your parent or guardian must be attached to this application.)

Have you participated on previous MANO of Hope teams? Yes No
If so please list the two most recent:

Print and sign your name below. Attach your deposit and signed consent form (if required) to this application **(\$400.00 is required with each application).**

| | | |
|-----------------|-----------|-------|
| _____ | _____ | _____ |
| Print Name | Signature | Date |
| _____ | _____ | _____ |
| Parent/Guardian | Signature | Date |

Deliver signed application, necessary deposit and all accompanying forms

La MANO of HOPE
Global Impact Teams
515 E. Wilson Boulevard
Hagerstown, MD 21740



GLOBAL IMPACT TEAM

PART II

MEDICAL RELEASE QUESTIONNAIRE

Name _____ Date of birth _____ Sex M F

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Medical Insurance Co. _____ Policy# _____

Policy Group # _____

Primary Physician _____ Phone # _____

ALL INFORMATION WILL BE CONFIDENTIAL. Please circle "Yes" or "No" and provide additional details when required.

1. Are you allergic to any medications? Yes No List _____

2. Are you currently taking any medications on a regular basis? Yes No
Please list reasons _____

3. Have you ever had a seizure? Yes No When _____

4. Have you ever been told by doctor you have epilepsy? Yes No When _____

5. Have you ever been treated for diabetes? Yes No When _____

6. Have you ever had a serious accident? Yes No When _____

7. Do you have a history of high blood pressure? Yes No When _____

8. How many times a week do you exercise? _____

9. Do you have or ever had the following illnesses/diseases:

| | | | | | | | |
|-----------------------|-----|----|------------|----------------|-----|----|------------|
| Hay fever | Yes | No | When _____ | Heart Disease | Yes | No | When _____ |
| Fainting Spells | Yes | No | When _____ | Lung Disease | Yes | No | When _____ |
| Frequent Diarrhea | Yes | No | When _____ | Kidney Disease | Yes | No | When _____ |
| Severe Stomach Aches | Yes | No | When _____ | Liver Disease | Yes | No | When _____ |
| Ear Ache or Infection | Yes | No | When _____ | Hepatitis | Yes | No | When _____ |

10. Have you ever been told by a doctor you have Asthma? Yes No When _____

11. Have you ever had shortness of breath or chest pain? Yes No When was the last time _____

12. Have you ever had a concussion or head injury? Yes No When _____

13. Have you ever stayed overnight in a hospital? Yes No When _____

14. Have you ever experienced travel anxiety? Yes No When _____

15. Date of your last Tetanus Shot (Must be within 10 years) _____

16. Other medical conditions not listed _____

The above medical history questionnaire is correct to the best of my knowledge, and I am able to engage in all activities, except as noted by a physician and myself. (Please attach any notes by a physician or yourself.)

I hereby give authorization for La MANO of HOPE Global Impact Team leader and or any Health Care Provider to provide medical attention, transportation and emergency medical services as warranted by the circumstances.

Print name: _____

Signature: _____

Date: _____



GLOBAL IMPACT TEAM

PART III

CONSENT TO PARTICIPATE

Approval By Parents or Guardians

(For youth participants under the age of 18 years of age, participating in La MANO of HOPE Global Impact Teams)

First and middle name of participant Last name

Address Date of Birth (MM/DD/YYYY)

Additional address (need street address if you have a P.O. Box)

City State Zip Code

Home Telephone No. Parents Cell Phone Number

Approval

(If two parents/guardians both need to sign.)

FOR: _____ **ON** _____
Name of project Date (MM/DD/YYYY) – (MM/DD/YYYY)

PARENT/GUARDIAN. Please read all of the statements on this page before giving your approval for participation in the activity listed above. I hereby approve and agree to all of the terms, conditions, and waivers of claims of this CONSENT FORM and certify its correctness. Further, I agree that this participant can meet the health and physical fitness requirements of this trip.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Medical Release: In the event of illness or injury occurring on my son or daughter while involved in this La MANO of HOPE Global Impact Team, I consent to X-ray examination, anesthesia, and/or medical or surgical procedures or treatment considered necessary in the best judgment of the attending physician and performed by or under the supervision of a member of the medical staff of the hospital furnishing medical services.

It is understood that in the event of a serious illness or injury, reasonable efforts to reach me will be attempted.

Insurance Company _____ **Policy No.** _____

Physician _____ **Telephone No.** _____

La MANO of HOPE; 515 E. Wilson Boulevard; Hagerstown, MD 21740; 301-787-6809; 301-739-1176 (fax)

www.manohope.org