



Bucerias, Nayarit, Mexico Mission Trip Application
Dates of Trip: Nov 11 - Nov 16, 2009

Please type or print

Name on Passport: _____

Address _____
Street _____

City _____ State _____ Zip _____

Date of Birth: _____ Sex: M _____ F _____ Valid Passport (mandatory): Y _____ N _____
*Due to liability all applicants must be at least 12 years of age. Circle of Concern reserves the right to refuse any application for any reason.

Country of Citizenship: _____ Country of Residence: _____

Passport/Greencard #: _____ Expiration Date: _____

Home Phone: _____ Home Email: _____

Work Phone: _____ Work E-mail: _____

Fax #: _____ Cell Phone: _____

Name of Home Church: _____
*If first trip, Pastor's Reference may be required.

Emergency Contact: _____ Phone # _____

What is your occupation &/or specialskills? _____

What areas of ministry are you interested in serving? (check all that apply) We will try to comply with your choices.

- ___ Children's Ministry Program ___ Vision/Glasses Team
___ Painting and repairs ___ Medical team
___ Evangelism ___ Dental Team
___ Translator ___ Prayer Team (meets early AM for 1 hour before team schedule)

Do you speak Spanish? _____ Fluently? _____ A little? _____

***Please be aware that your agreement to participate in this trip requires your commitment to attend and be on time for all meals, devotions, church service and any other ministry functions.

Please sign here: _____ (unsigned applications will be returned)

\$985 includes airfare, lodging, ground transportation, COC t-shirt ,1 dinner, 4 breakfasts, Children's program supplies, medical and construction materials. Tshirt (IMPT: CIRCLE size) S M L XL Men's ___ Women's ___

A non-refundable deposit* of \$200 is due now with submission of application

For those booking their own airfare, Cost of trip is \$585 plus air. After \$200 deposit, balance of \$385 is due and payable by Sept 11

Those flying with us, 2nd payment of \$385 due Aug 11, 2009. \$400 balance due Sept 11, 2009.

Pay by credit card online at www.circleoc.com. Or send check along with application.

Please mail, fax or e-mail this application to: George Wakeling c/o Circle of Concern P.O. Box 98, Dana Point, CA 92629-0098, PHONE: 949.388-6400, FAX: 949.388.7152, george@circleoc.com

CIRCLE OF CONCERN
PARENTAL AUTHORIZATION TO CONSENT AND TREATMENT OF MINOR
(PLEASE PRINT ALL INFORMATION EXCLUDING SIGNATURES)

(Herein "Parent") _____ (Print) (Herein "Minor") _____ (Print)

(Herein "Parent") _____ (Print) (Herein "Designated Agent") _____ (Print)

The above-named Parent of the Minor has entrusted the Minor into the care of Designated Agent, while the Minor participates in an activity sponsored by the Designated Agent, and for the welfare of the Minor.

The Parent does hereby authorize the Designated Agent to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act or of the laws of the State or Country in which the medical care is being sought and on the medical staff of any hospital; or to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered to the Minor by any dentist licensed under the California Dental Practice Act or the laws of the State or Country in which the dental care is being sought.

It is understood that this authorization is given in advance of any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power on the part of the Agent to give specific consent to any and all such examination, anesthetic, diagnosis, treatment, or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable.

The Parent hereby authorizes any hospital which has provided treatment to the Minor to surrender physical custody of the Minor to the Agent upon the completion of treatment. This authorization is given pursuant to Section 1283(a) of the Health and Safety Code of California, and similar provisions of the laws of the state or country in which the medical or dental care is being provided. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and similar provisions of the laws of the state or country in which the medical or dental care is being sought. The Parent hereby agrees to fully pay all costs of medical or dental care incurred for the Minor by the Agent under this authorization.

These authorizations shall remain in effective until revoked in writing and delivered to said Agent.

Dated: _____
_____ (Parent)

MEDICAL INFORMATION

Insurance Company: _____
Claim Office Address: _____
Claim Office Telephone Number: _____ Policy # _____ Group # _____
Employer Name and Address: _____
Number Where Parent Can Be Reached: _____
Special Medical Conditions of Minor such as Diabetes, Allergic Reactions, Medications Currently Using: _____

Pediatrician Name: _____ (Telephone): _____
(Address): _____

CIVIL CODE OF CALIFORNIA, SECTION 25.8

Either parent if both parents have legal custody, or the parent or person having legal custody or the legal guardian, of a minor may authorize in writing any adult person into whose care the minor has been entrusted to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act or to consent to an X-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to the minor by a dentist licensed under the provisions of the Dental Practice Act.

HEALTH & SAFETY CODE, SECTION 1283(a)

No health facility shall surrender the physical custody of a minor under 16 years of age to any person unless such surrender is authorized in writing by the child's parent or the person having legal custody of the child.

RELEASE FORM

I, the Parent or Guardian of _____ give my permission for participation in the programs & events of Circle of Concern. I hereby remise, release and forever discharge Circle of Concern, its employees, agents, servants and all other persons, firms and corporations whomsoever of and from any and all actions, claims and demands, whatsoever which claimant now has or may hereafter have on account of or arising out of any accident, casualty and/or action which might happen while participating in programs/events. I further understand that there is no Worker's Compensation or Accident Insurance furnished by Circle of Concern for such programs/events.

I acknowledge that I am responsible for any and all medical expenses of the above noted minor while participating in all programs/events, and agree to hold harmless Circle of Concern of any and all liability that may arise out of such participation.

Date: _____

Signature of Parent or Guardian

Relationship to Minor

ADDRESS: _____

TELEPHONE: (Day) _____ (Night) _____ E-MAIL _____

ADDRESS _____

DATE OF BIRTH: _____ (Minor)

AFFIDAVIT OF TEMPORARY GUARDIAN

AND CONSENT TO TRAVEL

(required for minor children)

I, (we) mother, _____ and father _____

of _____, do hereby grant to _____

TEMPORARY GUARDIANSHIP and further do hereby consent that our Son/daughter travel to

_____ with _____

for the period of time beginning on _____ and continuing until _____

_____ .

Said named person shall have all the powers and authority over our Son/daughter that we would have if we were present.

(Parent's Signature)

(Parent's Signature)

SUBSCRIBED AND SWORN TO THIS _____ DAY OF _____, 200__.

_____ NOTARY PUBLIC

My commission expires: _____