



Dates of Trip: May 20 - 24, 2010

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 Person who will be Guardian for Minor on trip _____

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

Emergency Contact: _____ Phone # _____

What is your occupation? _____

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

- Children's Ministry Program
- Medical team
- Dental Team
- Vision/Glasses Team
- Do you play a musical instrument? Which one? _____
- Painting and repairs
- Evangelism
- Translator
- Prayer Team (meets early AM for 1 hour)

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)

US \$935 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 \$100 is due now with submission of application.

For those booking their own airfare, Cost of trip is \$535 plus airfare. After \$100 deposit, balance of \$435 is due and payable by April 1.

Those flying with us from LAX, 2nd payment of \$435 due March 1, 2010. \$400 balance due April 1, 2010.

Pay by credit card online at www.circleoc.com. Or send check along with application. *** If the payment schedule is a hardship for you, please feel free to talk with us. We are willing to work you on a more stretched out payment plan.*

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

(Herein "Parent") (Print)

(Herein "Minor") (Print)

(Herein "Parent") (Print)

CIRCLE OF CONCERN

(Herein "Designated Agent")

The above-named Parent(s) 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 Signature)

MEDICAL INFORMATION

Insurance Company: _____ Claim Office Phone #: _____

Policy # _____ Group# _____ Policy Holder Name _____

Special Medical Conditions of Minor such as Diabetes, Allergic Reactions, Medications Currently Using:

Pediatrician Name: _____ Telephone: _____

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: _____

Parent Signature

TELEPHONE: (Day) _____ (Night) _____

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 _____, 2010.

_____ NOTARY PUBLIC

My commission expires