

YWAM OZARKS - HIGH SCHOOL OUTREACHES INDIVIDUAL PARTICIPANT APPLICATION

To be filled out by each outreach participant

PERSONAL INFORMATION:

Last/Family Name: _____ First: _____ Middle: _____

Current Address: _____

City: _____ State: _____ Postal/Zip Code: _____

Phone Number: _____ Cell: _____

Email: _____ Date of Birth: MM/DD/YYYY: _____

Age: _____ Gender: M / F Grade in School: _____

Work Experience/Skills:

INDIVIDUAL LIABILITY RELEASE FORM

We hereby release YOUTH WITH A MISSION OZARKS and its staff and volunteers from any liability whatsoever. These may include any illness, injury, damage, or loss that may occur during the course of involvement with YOUTH WITH A MISSION OZARKS, by means of reconciliation or arbitration and waive any right to pursue action by way of litigation.

We hereby understand that YOUTH WITH A MISSION OZARKS does not provide health insurance. We also understand that it is the responsibility of the participant to have insurance. YOUTH WITH A MISSION OZARKS will not cover any cost incurred by injuries, illness or death.

Applicant's Name: _____

Signature of parent or guardian: _____ Date: _____

Relationship: _____

YWAM PHOTO RELEASE

I, (please print your name) _____, give YWAM OZARKS, the right and permission to use my photograph in its promotional material and publicity efforts. I understand that the photographs may be used in a publication, print ad, direct mail piece, electronic media (e.g. video, CD-Rom, Internet), or other form of promotion. I release YWAM Ozarks from liability for any violation of any personal or proprietary right I may have in connection with such use.

Signature: _____

If applicant is under 18 years of age, the signature of a parent or responsible party is required.

Parent/Guardian: _____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY CONTACT:

Full Name: _____

Relationship: _____

PO Box/Street Address: _____

City: _____ State/Prov: _____ Postal/Zip: _____

Country: _____ Phone: _____ Fax: _____

Office: _____ Email: _____

HOME CHURCH:

Name: _____ Pastor's Name: _____

Denomination: _____

PO Box/Street Address: _____

City: _____ State/Prov: _____ Postal/Zip: _____

Country: _____ Phone: _____ Fax: _____

Office: _____ Email: _____

CONSENT FOR TREATMENT:

In case of emergency, I/we hereby agree to the performance of such treatment, including anesthesia and surgery, as the attending doctor or physician may deem necessary.

Applicant's Signature: _____ Date: _____

Signature of parent or guardian required if the applicant is under 18 years of age:

Signature: _____ Date: _____ Relationship: _____

CONFIDENTIAL HEALTH FORM

Last/Family Name: _____ First: _____ Middle: _____

Address: _____ Phone: _____

Height: _____ Weight: _____ Blood Type: _____ O, A, B, AB, (+ or -)

Date of Birth: MM/DD/YYYY _____ Age: _____ Birthplace: _____

Do you have medical insurance? N / Y

Name of Insurer: _____ Policy# _____

PERSONAL HISTORY

Have you ever had or do you now have any of the following:

Skin Condition	N/Y	Low Blood Pressure	N/Y	Have you ever had of the	
Eye Trouble	N/Y	Allergy: Bee Stings*	N/Y	following Communicable Diseases:	
Head Injury	N/Y	Allergy: Penicillin	N/Y		
Recurrent Headaches	N/Y	Allergy Sulfonamides	N/Y	Chicken Pox	N/Y
Epilepsy	N/Y	Allergy: Serum	N/Y	Measles (Rubella)	N/Y
Fainting Spells	N/Y	Heart Trouble	N/Y	Measles (Rubeola)	N/Y
Weakness	N/Y	Tumor/Cancer	N/Y	Mumps	N/Y
Paralysis	N/Y	Rheumatism/Arthritis	N/Y	Pertussis	N/Y
Insomnia	N/Y	Back Problems	N/Y	Scarlet Fever	N/Y
Shortness of Breath	N/Y	Dislocation of Joints	N/Y	Tuberculosis	N/Y
Hay Fever	N/Y	Duodenal Ulcer	N/Y	Other (specify)	_____
Asthma	N/Y	Gall Bladder Problems	N/Y		
Hepatitis	N/Y	Jaundice	N/Y		
Recurrent Diarrhea	N/Y	Intestinal Troubles	N/Y		
Kidney Disease	N/Y	Diabetes	N/Y		
Venereal Disease	N/Y	Anemia	N/Y		
High Blood Pressure	N/Y	Mental/Nervous Disorders	N/Y		

*If you are allergic to bee stings, please bring your own up to date reaction kit.

Are you allergic to any foods? N/Y Specify: _____

Other illnesses or conditions: _____

Are you at present under a doctor's care for any condition? N/Y specify:

Do you have a history of emotional instability or psychiatric treatment? N / Y

If "yes" when: _____ For how long: _____ Still in treatment? N / Y

Please explain: _____

Are you currently taking medication for depression? N / Y

Have you struggled with self-wounding or cutting? N / Y

Do you have any history with:

Eating disorders N / Y Drug or alcohol abuse N / Y

If "yes" to any above, when: _____ For how long: _____

Currently? N / Y

Do you have any physical impairments, handicaps, or health conditions, which require special attention? N / Y Specify: _____

Do you have any special dietary needs? _____

Have you been tested for HIV? N / Y If "yes" what were the results? Neg / Pos

Have you had any surgeries in the last twelve months? N / Y Specify: _____

Do you wear contact lenses or glasses? N / Y Specify: _____

Do you have a backup pair in case of loss? N / Y

FAMILY HISTORY

Have any of your relatives had any of the following:

		Relationship
Tuberculosis	N / Y	_____
Diabetes	N / Y	_____
Heart Disease	N / Y	_____
Arthritis	N / Y	_____
Asthma	N / Y	_____
Hay Fever	N / Y	_____
Stomach Disease	N / Y	_____
Epilepsy	N / Y	_____
Hypertension	N / Y	_____
Cancer	N / Y	_____
Other (specify)	N / Y	_____

Please fill in completely and return to:

YWAM Ozarks • 7119 Mountain View Dr. • Ozark, AR 72949 • 479-667-1152