

WISCONSIN Volunteers In Mission
National Work Camp Participant Registration/Information Form

Work Camp in _____ on _____
(location) (dates)

This form needs to be completed, signed, and returned with the deposit to the registrar/leader of the work camp.

Name of Volunteer _____ Date of Birth _____

Address _____ City, State, Zip _____

Phone: _____ Cell Phone _____ Email: _____

Please check one: I plan to ride the bus: _____ or I plan to drive on my own: _____

Please check one: I wish to apply for a scholarship: YES _____ or NO _____

My work skills are: _____

Enclosed is a deposit of \$_____. If needed, I can use a top bunk: YES _____ or NO _____

Health Care Power of Attorney:

If I am unable to make health care decision for myself, due to my incapacity, I hereby designate _____, (another adult on trip or work camp leader), to be my health care decisions on my behalf. In the event that I am incapacitated, I instruct any health care provider to obtain the health care decision from my health care agent, for all of my health care and treatment. My health care agent is instructed to make health care decisions for me, but my health care agent should try to discuss with me any specific proposed care if I am able to communicate in any manner, including blinking my eyes.

If I cannot communicate and have not otherwise expressed a health care choice to my health care agent, the health care agent shall base his or her health care decision on what he or she believes to be in my best interests. Such decisions could include, but are not limited to, examinations, administration of anesthetic, medical diagnosis, surgery, treatment and or hospital care, including the provision or withholding of feeding tubes and /or life support, and admission to nursing homes, hospitals or other treatment facilities.

Emergency Contacts and Phone Numbers

1. Next of Kin _____ Relationship _____ City, State _____ Phone _____

2. Other contact _____ Relationship _____ City, State _____ Phone _____

3. Other contact _____ Relationship _____ City, State _____ Phone _____

Insurance Information:

Name of Primary Medical Insurance Company _____

Policy Number _____ Group Number _____ Insurance Company Phone Number _____

Name of Secondary Medical Insurance Company _____

Policy Number _____ Group Number _____ Insurance Company Phone Number _____

Medical Information

List any health problems, needs, disabilities that you have: _____

List any allergies, special needs, or special sleeping accommodations: _____

Attach a List of Medication that you take with the exact dosage OR list here: _____

If necessary, attach an additional sheet for further Medical Information.

Photo Use: I give permission for pictures of me taken during work camp to be used for future promotions. YES _____ NO _____

Christian Conduct:

I understand that team members must be flexible, cooperative, and cheerful. I agree to cooperate at all times with the team leader, team members, and the host agency concerning daily assignments, food, lodging, and transportation. I agree to stay with the team from beginning to end, to abstain from the use of alcohol and tobacco while on the mission trip, to conduct myself in an appropriate Christian manner, and to share my faith to the best of my ability.

LIABILITY RELEASE FORM

I understand that I am about to embark on travel into circumstances with unknown personal safety and/or sanitary conditions. I understand that there is inherent risk in the activity which I am undertaking. Because I understand the inherent risk in this undertaking, I agree to release and hold harmless the Volunteer in Mission, the Work Camp Leaders, the Host Agency, the Wisconsin Conference of the United Methodist Church and any related agency, general church agency, conference, district, local church, member, employee or agent from any liability for personal injury, damages, loss, accidents, and/or delays resulting from my participation in the Volunteers in Mission project. This release is given in consideration of Volunteers in Mission's efforts in making arrangements for my participation. This release is intended to bind me, my heirs, and personal representatives.
If participant is under 18 years of age, parent/guardian must also sign this form.

By signing below, I confirm that I agree to comply with All the above.

**Signature of Participant _____ Date _____

**Witness _____ Date _____

REMINDER: Make a list of medications and dosages on the back or attach it.