



Lutheran Church of Hope Mission Trip Registration

- A non-refundable deposit of \$150.00 is required per person for all trips except Mission Navajo. The non-refundable deposit for Mission Navajo is \$170.00 per person.
- Forms can be returned to: Lutheran Church of Hope, 925 Jordan Creek Pkwy., West Des Moines, IA 50266 – or they can be faxed to: 515-267-8136.
- Make checks payable to HOPE with the trip name in the memo and turn in at the front office.
- When submitting your registration, please provide a copy of your insurance card (front & back). For international travel, you must also provide a copy of your passport (and VISA for Mission Ghana).
- To register a family, complete only one registration form and list all names and birthdates of those registering in the area below.
- Type names exactly as they appear on your travel documents.
- Questions? Contact Dina Remington (dina.remington@hopewdm.org) or Wendy Liskey (wendy.liskey@hopewdm.org) or call 515-222-1520.

Trip Name: _____ Trip Dates: _____

Full Name: (as it appears on Travel Photo Identification):

Address:

City, State, Zip:

Home Phone () Work Phone () Cell Phone ()

Email Address: Marital Status: S M

Birth Date: Age: Gender:

List all family members' names and birthdates who are also registering for this trip:

Emergency Contact Information

Name: _____ Relationship: _____

Home Area Code/Phone #: _____ Work Area Code/Phone #: _____ Cell Area Code/Phone #: _____

Skills and Gifts

Please circle any areas in which you are proficient:

Plumbing	Musical gifts	Computer	Masonry	Arts/Crafts	Farming
Electrical	Teaching	Healthcare	Painting	Administration	

Please give details for any skills selected above or describe any other skills not listed:

-- Please complete both pages of the form --

Health Information

Health Insurance Carrier:

Phone:

Policy #

(Please attach copy of insurance card to form)

Rate your general health: Excellent Good Poor

State any special needs (diet, lodging, lifting, etc.)

Indicate any chronic health conditions and surgeries or serious illnesses in the past five years:

Indicate any allergies (environmental, food, medication):

Indicate date of last tetanus shot:

(Note: Mission Ghana registrants must also have proof of Yellow Fever vaccination to enter Ghana.)

List any medications you will be taking on this trip (Note: if you are leaving the country, all prescription medications must be carried in the original containers):

Mission Insurance Information

Lutheran Church of Hope purchases short-term missionary insurance on your behalf during the trip dates. Please provide the individual name(s) and phone number(s) to list as the beneficiary on the life insurance portion of the policy. You must provide a beneficiary for each family member participating.

Name:	Phone:
Name:	Phone:
Name:	Phone:
Name:	Phone:

Out of Country Travel - Please complete for Mission Ghana, Jamaica, South Africa, Uganda or Umzimvubu.

Passport # Exp. Date: (Please attach copy of passport to form)

Indicate T-shirt Size: Small Medium Large X-Large XX-Large

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation with Lutheran Church of Hope, every reasonable effort will be made to contact the person(s) listed on this form. If unsuccessful in contacting the person(s) listed, consent/permission is given for treatment by competent medical personnel.

Further, unless specified otherwise, consent/permission is hereby given to all accompanying adult volunteer leaders on the trip to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under recommendation of qualified medical personnel). If possible, the adult contact person for your group should make the final decisions in cooperation with medical personnel.

I understand that Lutheran Church of Hope does not carry accident or medical insurance on participating volunteers. I agree that my insurance company will be used for such medical care expenses and I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance. I understand that if I do not have medical insurance coverage that I am responsible for the payment of any medical bills.

Signature: _____ **Date:** _____

Signature of parent if participant is a minor: _____ **Date:** _____

Your Mission Leader will carry a copy of this form during the trip.