HCP Application, Medical Information & Liability Waiver

Please complete the following information. If you have questions, contact your team leader.

NOTE: A $ 250 non-refundable deposit along with your application will secure your spot on the team of your choice. For more information, please go to:
https://www.hondurascompassion.org/teams/general-team-info/
***Denotes required information**

Name * As it appears on your passport

First

Last

Date of Birth *

_____ _____ _____
MM DD YYYY

Address *

Street Address

Address Line 2

City

State / Province/ Region Zip / Postal Code

Phone number * **Email** *

Citizen of *

[ ] USA [ ] Canada [ ] Other_____

You must have a passport valid at least 6 months from your trip date. If your passport was issued by a country other than the US, please verify any entry requirements before traveling.

Passport Number *	**Passport Expiration Date** *
	____ ____ _____ MM DD YYYY

Known Traveler Number (if applicable)

Enter your KTN if you have one. This will give you access to TSA Pre-Check lines on domestic legs.

Which Team Are You Applying For?_____

T-Shirt Size: Please check box if you need Youth size [ ] or Adult size [ ]

S	M	L	XL	XXL	3XL

Emergency Contact *	**Relationship to Applicant**

Emergency Contact Phone Number *

Physician Phone Number *

Do you speak Spanish? *

Known Medical Conditions *

Please note any known medical conditions that staff should be aware of. Note "NA" if none.

Current Medications & Dosage *

Please note any medications. This information will be provided to medical attendants in case of emergency. Note "NA" if none.

Allergies *

List any allergies our staff should be aware of. Note "NA" if none.

Food Restrictions

Please share any food restrictions. Our staff will do their best to accommodate your needs.

Signature *

By signing below, I authorize the personnel of Honduras Compassion Partners and/or available medical personnel to obtain and administer emergency medical treatment for me should I become ill or incapacitated while on this HCP-sponsored mission trip. In an emergency, I give my permission toa licensed physician to hospitalize, anesthetize, or perform surgery as needed. I understand that every reasonable effort will be made to contact my family before these actions are taken. Additionally, by signing this form, I acknowledge that any travel, volunteer work, or other activities I undertake in connection with Honduras Compassion Partners, partnering agencies, organizations, or individuals involves inherent risk on my property, health, and life and I further understand the nature of such risks. By signing, for myself and/or heirs, I freely and knowingly waive any and all actions, causes of actions, claims, and demands for or by reason of loss of life, bodily injury loss, including, but not limited to the contraction of any endemic diseases, costs, damage, or expense for any act or omission on the part of a third party or on the part of Honduras Compassion Partners or any of its officers, agents, servants, employees or anything in any way arising from or connected with either directly or indirectly, any volunteer activities of the undersigned Volunteer of. This agreement is intended to be broad and inclusive as permitted by the laws of the State of Maryland. This agreement is to be governed by the laws of the State of Maryland. If any portion of this agreement is held invalid, it is agreed that the remainder shall nevertheless continue in full force and effect.

_____ _____

Signature Today's Date mm/dd/yyyy