



Grosse Pointe Memorial Church

High School Mission Trip Registration Form for Youth

Appalachian Service Project – June 26 - July 3, 2022

Triennium – July 24 - 27, 2022

I am registering for:

Mission Trip

Triennium

Both!

Use the checklist to ensure registration is complete:

Complete Registration packet

Notarized Health form

A copy of both sides of your Health Insurance card

A completed Physician's Report, if applicable

\$100 Deposit Per Trip

Participant Name

Parent(s)/Guardian(s) Name

Street Address

Home Phone

City

Zip

Phone: Dad's cell Mom's cell Other

Family e-mail address: *Please print clearly.*

Phone: Dad's cell Mom's cell Other

Youth e-mail address: *Please print clearly.*

Youth cell phone number

Do we have permission to contact you and/or your child by text via the Remind.com app? _____

Grade attending _____

T-shirt size _____ (XL, L, M, S, XS)

Return all items to the Christian Education Office at
Grosse Pointe Memorial Church by February 15, 2022.

Registration is complete once you receive an email from GPMC.

Checks should be made out to "Grosse Pointe Memorial Church" (or "GPMC")
with "2022 Youth Mission Trip" written in the memo line.



Grosse Pointe Memorial Church

16 Lakeshore Drive
Grosse Pointe Farms, MI 48236-3783
313.882.5330

[01] COVENANT AGREEMENT – YOUTH

This page must be completed and signed by the participant and their parent or guardian.
Return completed forms by **February 15, 2022**. This is required for participation.

Participant's name

COVENANT AGREEMENT

Each participant is expected to abide by the following for the 2022 high school mission trip:

1. I will participate in all activities and work hard. This includes activities leading up to the trip, like fundraising and orientation, as well as activities during the trip, like devotions, work days, and worship.
2. I will abide by all COVID safety protocols.
3. I will follow all instructions and pay special attention to safety rules.
4. I will respect others (and their property), including adult leaders, staff, and those we serve.
5. I will be on time.
6. I will not bring any electronic devices on this trip.
7. I will not spend time in others' sleeping quarters.
8. I understand that no one under the age of 25 shall drive a vehicle.
9. I will not fight or physically intimidate anyone.
10. I will not possess or use alcohol, drugs or tobacco.
11. I will not possess weapons, fireworks, lighters or explosives.
12. I will not do anything that will jeopardize the safety or experience of the group.
13. I understand this is a church mission trip and will act accordingly.
14. I will do my best to be safe and have fun!

Participants are required to initial the following:

_____ I have read the rules of conduct (stated above) and agree to abide by them.

_____ I am familiar with the information provided on my health form and physician report and agree to abide by the personal limitations stated on those forms.

_____ I understand the following: *Participants who fail to comply with these expectations will be picked up by a family member and sent home at their own expense.*

Participant signature

Date

Parent/Guardian signature

Date



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[02] LIMITED POA –
YOUTH

LIMITED POWER OF ATTORNEY

For Emergency Medical Treatment, Travel and Consent
June 23 - July 31, 2022

Name of Dependent: _____ Birth date: _____

Allergies/Illnesses: _____

Medications being taken: _____

I hereby grant to the following individuals:

Rev. Sarah Godbehere, Margaret Mollison, or any of the designated Advisors of the Grosse Pointe Memorial Church (U. S. A.), 16 Lakeshore Drive, Grosse Pointe Farms, MI 48236-3783, (313) 882-5330, the Limited Power of Attorney to act for me by giving the required consents and authorizations for travel and for the delivery of necessary medical care, diagnoses and treatment to the above-named child and to do all other necessary things as I might or could do if personally present. Any Advisor may act under this Power of Attorney.

This limited power of attorney is given pursuant to the provision of P.A. 1998 No. 386, Section 5103 of the Estates and Protected Individuals Code, as amended, and is effective June 23 - July 31, 2022. I agree to accept responsibility for all expenses incurred for medical treatment for the above-named child.

Signature of Parent or Legal Guardian Relationship to child Date

Street Address City, State, Zip

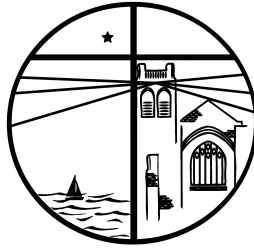
Phone: Home _____ Work: _____

Dad's Cell _____ Mom's Cell _____

Health Insurance Company _____ Policy Numbers: _____

Emergency Contact's Name Relationship to child

Home Work Cell



Grosse Pointe Memorial Church Photo Release Form

I hereby grant permission to Grosse Pointe Memorial Church to use my and/or my minor child's photograph on its World Wide Website or in other official Memorial printed publications for the purpose of promoting Memorial ministry without further consideration, and I acknowledge Memorial's right to crop or treat the photograph at its discretion. I also acknowledge that Memorial may choose not to use my photo at this time, but may do so at its own discretion at a later date.

To maintain privacy, all photographs of minors will have first names published only. I also understand that once my image is posted on the Grosse Pointe Memorial Church website, the image can be downloaded by any computer user on or off church property and I agree not to hold the church responsible in such event.

I DO GIVE Grosse Pointe Memorial Church permission to use my and/or my child's name and photograph on the church's website or other official Memorial printed publications.

I DO NOT GIVE Grosse Pointe Memorial Church permission to use my and/or my child's name and photograph on the church's website or other official Memorial printed publications.

Parent/Guardian's Name: _____

Name of Child: _____

Parent/Guardian Signature: _____

Date: _____



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[03] HEALTH FORM — YOUTH

This page must be completed, signed by parent/guardian, and **notarized**.
Return completed forms by **February 15, 2022**. This is required for participation.

Name of Participant: _____ Date of Birth: _____ Age: _____

Street Address: _____ City, State, Zip: _____

Parent/Guardian: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Second Parent/Guardian or Emergency Contact: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Family Doctor: _____ Phone: _____

Family Dentist/Orthodontist: _____ Phone: _____

Family Health Insurance Carrier: _____

Contract No. _____ Group No: _____ ***A copy of the card must be submitted.***

HEALTH RECORD (Please fill in all information requested.)

Date of last tetanus shot: _____

*(Booster date is important in case of accident.
Note: Tetanus is included in TDAP, DPT, and DT)*

Last Tuberculin Test: _____

Covid: _____

TDAP, DPT, or DT: _____

Oral Polio: _____

Measles: _____

Rubella (German measles): _____

Mumps: _____ or, MMR: _____ *(Measles, Mumps, Rubella in one dose)*

Does your child suffer from, or has ever experienced, or is being treated currently for any of the following:

- | | | | |
|--------------------------|---------------------|---------------|----------|
| asthma | epilepsy / seizures | heart trouble | diabetes |
| frequently upset stomach | physical handicap | other _____ | |

List and explain any additional major illnesses or surgeries your child experiences during the past 12 months.
Additional comments may be attached on a separate sheet.

Is youth participant in reasonably good health and free of contagious disease? Yes No

Should this student's activities be restricted for any reason? Yes No

If yes, please explain: _____

Has this student had a physical examination within the last 24 months? Yes No

If no, see Physician's Report on next page.

Allergies:

Does youth participant have any allergies to —

Pollens Medications Food Insect Bites

Other: _____

Description of allergies: _____

Describe symptoms or reactions: _____

Are any medications or treatments helpful? _____

General Health:

For your child's safety, and our knowledge, is your child a:

Good Swimmer Fair Swimmer Non-Swimmer

Does your child wear:

Glasses Contact Lenses All the Time Occasionally

Please list any additional dietary considerations: _____

(Name of participant)

has my permission to participate in the High School Mission Trip/Triennium and all subsequent activities connected with the trip. I confirm that the information provided above is correct, to the best of my knowledge.

I give permission to the physician or hospital selected by the church authorities to secure proper treatment, to hospitalize, and to order injections, anesthesia, or surgery for the above participant. We agree to assume all responsibilities for medical payments for sickness and accident. I AGREE TO INDEMNIFY AND HOLD HARMLESS GROSSE POINTE MEMORIAL CHURCH AND THE ADULT ADVISORS ACCOMPANYING MY CHILD FROM ANY CLAIM OF LIABILITY WHATSOEVER ARISING FROM THE TRIP.

Parent/Guardian Signature _____ Date _____

Printed Name _____

Notary Public County and State Date

If youth participant is bringing medication on the trip, has a chronic/handicapping condition, or has not seen a physician in the last 24 months, the **Physician Report Form** must be completed and signed by physician.



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**[04] PHYSICIAN
REPORT – YOUTH**

This page must be completed and signed by Physician. **Return completed by February 15, 2022.**
Form is required for participation if youth participant is bringing medication on the trip, has a chronic/
handicapping condition, or has not seen a physician in the last 24 months.

Name of youth participant _____

Date last seen by Physician _____

Is there a diagnosis that may impact the youth’s participation on this trip?

No

Yes: _____

Youth Participant has medication: For regular use For use as needed None

Drug	Dose	Time / Administration
_____	_____	_____
_____	_____	_____

Special instructions or general precautions concerning this youth participant (any recurring illness, any treatments as needed, meal or dietary restrictions, etc.):

In my medical opinion, the person named above:

is able

is not able to participate in the youth trip(s), the work that is to be done, and the subsequent activities of the group.

Physician Signature _____ Date _____

Printed Name: _____