



Moveolution Application

1. Legal Name:

Title:

First Name:

Other Names:

Family Names:

2. Contact Details:

Present Address:

Telephone:

Mobile:

Email:

Facebook:

3. Date of Birth:

4. Gender: Male/Female (please circle)

5. Emergency Contact:

Name:

Relationship to you:

Address:

Postcode:

Telephone:

Mobile:

Email:

6. Are you on any medication? Yes/No

If Yes, which medication?

What is this for?

7. Have you (in the last few years) or are you receiving counselling? If so please explain on separate paper.

What physical disabilities do you have?

Do you have any ongoing illnesses?

Are you a smoker: Yes/No

8. Are you a vegetarian? Yes/No

If yes would you eat some meat if you really had to? Yes/No

Do you have any food allergies or need a special diet?

Is there anything else you feel we need to know please tell us on a separate piece of paper.



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10. Data Protection Agreement: By signing below, you agree to relevant parts of your personal data (including sensitive data such as health) being passed on to other partners in the mission connection with your service. Your records will be handled responsibly. We may pass on your name, email address, and phone number on to other participants going on the same trip to co-ordinate travel and/or to get in touch with one another. You also agree to the use of your photo for further promotion of trips and of Reign Ministries in the coming years.

Signed:

Date:

11. Please explain below how you decided to commit your life to following Jesus? Tell us how long ago this happened to you. Say what you were like before you were a Christian, what you actually did to become a committed follower of Christ and how your life has changed since you made this commitment?



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12. While you are in Shirley you may have to explain what it means to be a follower of Jesus to someone. What would you say? (use extra sheet if necessary)

14. What are your reasons for going on the trip?



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Full name of the young person:

Date of Birth ___/___/___

Address:

Detials of any regular medication, medical problems (eg. athsma, epilepsy, diabetes, allergies, dietary needs, etc.) or disability which may affect normal activity:

Please state the date of the last anti-tetanus injection if know: ___/___/___

With whom does your child live?

Telephone number: Day: Evening:

Name and telephone number of additional contact (grandparent etc or other holding parental responsibility)

If you do not have parental responsibility (eg you are a foster carer/grandparent etc) please give detials of those with parental responsibility.

Name:

Address(es)

Telephone number(s)

**I give my permission for _____ to take part in the normal activities of this group. I understand that while involved he/she will be under the contral and care of the group leader and/or other adults approved my the missions leadership and that, while the staff in charge of the group will take all reasonable care of the children, they cannot necessarily be held responsible for any loss, damage or ingury suffered by my child during, or as a result of the activity. In an emergency and/or if I am not contactable. I am willing for my child to receive necessary hospital or dental treatment including an anesthetic (YES/NO)
Signed: (parent/ or adult with parental responsiblity)**