

# 2017 MISSION OF MIRACLES YOUTH APPLICATION

## Applicant Information

Name as it appears on your passport: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Passport Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do you Speak Spanish?    Yes        No            Very fluent        Some

Years of Spanish Study: \_\_\_\_\_

Church Affiliation (if any) \_\_\_\_\_

Please list any past or present medical conditions, allergies or dietary restrictions that we should be aware of: \_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any medications that we should be aware of? If Yes, please list them along with the dosage and frequency.

\_\_\_\_\_  
\_\_\_\_\_

Do you have any medical condition which would endanger you or others if you were to engage in strenuous exercise?

\_\_\_\_\_  
\_\_\_\_\_

Have you been on a medical mission in the past? If yes, when and where?

\_\_\_\_\_

