



**Holman Street**  
BAPTIST CHURCH  
"Hope Is Here"  
Murray G. Martin, Senior Pastor

## MISSION COVENANT

If selected to participate on a Holman Street Baptist Church group trip, I will abide by the following covenant, from the time I leave the Holman Street Baptist Church campus until I return to that campus. I will do the following:

1. Familiarize myself with the customs, cultures, and traditions of the country or region to which I will be traveling; respect all customs, cultures, and traditions; and act in deference to such customs, cultures, and traditions, which includes action or dress that will not be offensive to the people of the country or region to which I am traveling as described by the team leader and/or orientation leaders.
2. Respect the views and feelings of the other group team members and those of the host community.
3. Refrain from all conduct that may reflect poorly on myself and my work team, including consumption of alcoholic beverages, use of illegal drugs, gambling, or possession of weapons of any kind;
4. Refrain from the use of tobacco unless done in complete privacy or refrain if I am underage.
5. Support the group leadership.
6. Attend and participate in all activities in preparation for the trip. While on the group trip, attend and participate in all sharing sessions and devotions, contribute to team efforts, and share my experience with I return; (if asked)
7. Travel with the group to and from the site.
8. Be a true servant and representative of Christ, Christ's church, and Holman Street Baptist Church.

I understand that If I fail to abide by this covenant, I may be immediately returned to Houston, TX at my own expense and that I will reimburse Holman Street Baptist Church to the full cost of my trip over and above the portion paid for me.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## MEDICAL INFORMATION FORM

FULL NAME \_\_\_\_\_  
LAST FIRST MIDDLE

BLOOD TYPE (CIRCLE ONE)  
A- A+ B- B+ AB- AB+ O- O+ DON'T KNOW OTHER \_\_\_\_\_  
RARE BLOOD TYPE

INFORMATION ABOUT ANY PRESCRIPTIONS I USE  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I AM ALLERGIC TO  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### EMERGENCY CONTACT

FULL NAME \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME WORK

RELATIONSHIP \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

INSURANCE COMPANY  
\_\_\_\_\_

POLICY NO. \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
OFFICE FAX



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**PHYSICAL LIMITATIONS OR CONCERNS**

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I AM DIABETIC                     YES     NO  
I HAVE HYPERTENSION         YES     NO  
I HAVE ASTHMA                  YES     NO  
I HAVE A HISTORY OF SEIZURES    YES     NO  
I HAVE BACK PROBLEMS         YES     NO

**PLEASE PROVIDE OTHER HELPFUL HEALTH INFORMATION**

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I CONSIDER MYSELF HEALTHY ENOUGH TO FULFILL MY RESPONSIBILITIES ON THE GROUP TEAM.         YES     NO

Participant's Printed Name: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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Parent or Guardian Printed Name: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**MEDICAL RELEASE FROM**

I, \_\_\_\_\_ authorize \_\_\_\_\_  
(Volunteer Participant) (Another Adult of the trip)

Consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which they practice, during the duration of the trip identified below.

Group Trip or Activity \_\_\_\_\_

Date of Trip \_\_\_\_\_

Participant's Physician \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Allergies and Medication(s) \_\_\_\_\_

**PARTICIPANT'S HEALTH INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_

POLICY NO. \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
OFFICE FAX

Participant's Printed Name: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTARIZATION OF MEDICAL RELEASE FORM**

STATE OF TEXAS Soc. Sec. No. \_\_\_\_\_

COUNTY OF HARRIS IN THE CITY OF HOUSTON



**Holman Street**

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On this \_\_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_, before me personally appeared \_\_\_\_\_ to me known to be the same person described in and who executed the within instrument, and who acknowledged the same to be the free act and deed thereof.

\_\_\_\_\_  
Notary Public

**Harris**

County, State of

**Texas**

My Commission Expires \_\_\_\_\_

Copies Sent To:

Holman Street Baptist Church  
P.O. Box 1420  
Houston, TX 77251-1420



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**LIABILITY RELEASE FORM**

The undersigned releases and agrees to hold harmless Holman Street Baptist Church and any related agency, conference, district, local church, member, employee or agent from any liability, injury, damages, loss, accidents, delay or irregularity related to the undersigned planned participation or involvement in the following project:

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This release covers all rights and causes of action of every kind, nature, and description, which the undersigned ever had, now has, or but for this release, may have. This release binds the undersigned and his heirs, representatives and assigns:

Participant's Printed Name: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<b>LIABILTY RELEASE FORM</b>
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STATE OF TEXAS Soc. Sec. No. \_\_\_\_\_

COUNTY OF HARRIS IN THE CITY OF HOUSTON

On this \_\_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_, before me personally appeared \_\_\_\_\_ to me known to be the same person described in and who executed the within instrument, and who acknowledged the same to be the free act and deed thereof.

---

Notary Public

Harris County, State of Texas

My Commission Expires \_\_\_\_\_

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