

Impact Houston Church of Christ

Application for Summer Internship in Urban Youth Ministry

General Information:

Name: _____

SSN: ____-____-____

School Mailing Address: _____

Phone: (____) _____

Email: _____

Driver's License: _____

D.O.B. ____-____-____

Parent's Name(s): _____

Phone: (____) _____

Parent's Address: _____

How do you plan to be funded? _____



References

Name	Relationship	Phone
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Please send completed application to:

Impact Houston Church of Christ
Attn: Dennis Jaeger
1704 Weber St.
Houston, TX 77007

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Personal

What school do you attend? _____

What is your classification? _____ Major? _____

Please list your last two employers and briefly describe the position you held:

1) _____

2) _____

* What extra curricular activities are you involved in? (Use the back of this page if necessary):

* Describe your cross-cultural experience, or any other experiences, that you might consider a relevant learning tool towards urban ministry (Use back if necessary): _____

What ministry emphasis do you wish to participate with this summer (circle one)

High School

Middle School

VBS

* How do you think you can best contribute to this ministry this summer? _____

* What are your strengths and weaknesses as you see them in relation to ministry? _____

*What do you hope to gain through an internship at Impact this summer? _____

Please sign and date if Impact has permission to perform a background check on you:

Signature

Date

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MEDICAL INFORMATION & RELEASE FORM

 Last Name First Name Middle Initial

 Date of Birth

Social Security Number _____ - _____ - _____

Sex: ___ Male ___ Female

 Parent/Guardian Name

 Relationship

 Address
 (_____) _____

City/State

 Zip Code
 (_____) _____

Home Phone

Work Phone

If not available in an emergency, please contact:

Name _____

Phone Number (_____) _____

Family Physician _____

Phone Number (_____) _____

Insurance co. _____

Phone Number (_____) _____

Address _____

Insured's Name _____

Relationship _____

Insured's SSN _____

Group # _____

HEALTH

I consider my health to be: ___excellent ___fair ___poor

Contact Lenses? ___Yes ___No

Special Needs (i.e., diet restrictions, physical restrictions, etc.) _____

Problems requiring special attention _____

Allergies and Typical Reactions _____

List all medications you will bring with you, include dosage and reason for the medication _____

HEALTH HISTORY

Please check all that you have had:

- | | | | |
|---|---|--|------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Congenital Defect | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Migraine Headache | |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nervous Stomach | <input type="checkbox"/> Broken Bones: _____ | |
| <input type="checkbox"/> Operations _____ | | | |

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Please write a brief **Personal Testimony** of how you became a Christian and state your present commitment to the Lord Jesus Christ: