

Medical Form

Please complete this form and return it to your church representative or Melanie Harris.

We ask for this information so that our volunteers will know in advance of special medical conditions you may have, rather than learning about them in a crisis. Also, in the event of serious injury or illness, this form provides emergency medical personnel with a useful medical history. After reviewing this form, you may be contacted to discuss whether the trip will be safe and enjoyable for you considering your medical history. We will keep the information on this form confidential. It will be seen only by volunteers who need to know and understand its confidential nature. The form will be retained during the trip, after which it will be destroyed. If you choose not to go on the trip, this form will be destroyed immediately.

General Information

Name: _____ Gender: ___ Male ___ Female

Address: _____

City: _____ State: _____ Zip: _____

Home: (_____) _____ Cell: (_____) _____

E-mail address: _____ Date of Birth: _____

Occupation: _____ Height: _____ Weight: _____ Blood Pressure: _____

Emergency Contact: _____ Relationship: _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

If the above person is unavailable, please notify:

_____ Relationship: _____

Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Medical Insurance Information

We strongly encourage you to bring your insurance card or other documentation with you on the trip.

Company Name: _____ Policy Number: _____

Contact Phone Number (if applicable): (_____) _____

Allergies

Include medicines, foods, animals, insect bites and stings, and environment (dust, pollen, etc.).

Allergy Reaction Medication Required (if any) _____

Please continue on reverse

Medical History

Altitude Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intestinal/Bowel problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/Urine problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Life threatening problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone/Skeletal problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulation problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision/Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If you wear prescription glasses or contacts, we recommend bringing a spare set.

Do you have any other conditions or limitations that we need to be aware of? Yes No
If yes, please explain. _____

If you answered yes to any of the above questions, please list **ALL** prescription, over-the-counter, and natural **MEDICATIONS** you are taking. _____

List any special diet or special needs: _____

Recent illness? Yes No *If yes, please explain.* _____

Accidents, operations, hospitalizations? Yes No *If yes, please explain.* _____

Tetanus: It is strongly advised that you are inoculated against this fatal disease and you obtain a booster within every 10 years. Date of your most recent tetanus or booster: ____/____/____

Physician information

Family Physician's name: _____ Phone Number: (____) _____

Address: _____

Signature

Date completed