Short-Term Mission Trip Medical History

Legal Name: _____ Birthdate: ____/_____/_____ Gender: _____

Complete Home Address:_____

Home Phone: _____ Cell phone:_____

Email: _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Relationship to participant: _____

MEDICAL INFORMATION:

Primary Physician: _____ Phone #: _____

Insurance Company: _____ Policy #: _____

Name of person insurance is under: _____ Group #: _____

HEALTH HISTORY:

Do you have any physical limitations that would hinder your ability to participate in vigorous activities? If so, please explain. _____
_____
_ _____

Do you have any medical problems? If so, please explain.
_____
_____

Are you allergic to any medications or food? If so, please explain.
_____
_____
_____

Do you take any medication on a regular basis? If so, please list:
_____
_____
_____