Medical Information

Please complete the following and give to mission leader ***(mission team leader should retain this form on site to use in case of emergency.)***

Name _____

1. Blood type _____
2. Information about any prescriptions I use:

   I am allergic to:_____
3. Name of contact person: _____
   a. Street Address _____
   b. City _____ State _____ Zip _____
   c. Phone (work) _____ (home) _____(cell)_____
   d. Relationship to volunteer _____
5. My health insurance company is _____
   a. Policy number _____
6. Do you have any of these medical problems?

   Diabetes _____ Medication _____

   Heart _____ Medication _____

   Asthma _____ Medication _____

   Allergies _____ Medication _____

   History of seizures: Yes _____ No _____

   Back problems _____ Lifting _____ Bending _____
7. Please provide other helpful health information:

   Date of last tetanus shot _____
8. I consider myself healthy enough to fulfill my responsibilities on this mission team.

   Yes _____ No _____

Signature of Participant _____ Date _____