

**MEDICAL INFORMATION
FOR INDIVIDUAL VOLUNTEERS
(Every Volunteer Needs to Fill Out This Form)**

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 _____ Dates of mission trip _____

1. Blood type _____

2. Information about any prescriptions I use: _____

3. I am allergic to: _____

4. Name of contact person _____

a. Street Address _____

b. City _____ State _____ Zip _____

c. Phone (work) _____ (Home) _____

d. Relationship to volunteer _____

5. My health insurance company is _____

a. Policy number _____

6. Physical limitations or concerns: _____

7. I am diabetic: Yes _____ No _____

8. I have a history of seizures: Yes _____ No _____

9. Please provide other helpful health information: _____

10. I consider myself healthy enough to fulfill my responsibilities on the mission team. Yes _____ No _____

I, _____ (volunteer's signature), authorize _____ (team leader) to consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered under the general 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 above and further authorize the release of medical information from my personal medical records for the following purpose: _____ but I do not give permission for any other use or re-disclosure of this information.