

**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 a 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 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 purposes: \_\_\_\_\_ but

I do not give permission for any other use or re-disclosure of this information.