Mission Group

CONFIDENTIAL MEDICAL FORM

e ____________/______________/________________ Birthdate ____/____/____
First Middle Last

Address ______________________________/______________/_____/__________
Street City State Zip

Phone ________________ Cell ________________ Email ________________

Emergency Contact Person ________________________ Relationship ____________

Email ________________________ Phone ____________ Cell ____________

Physician Name ________________________ Phone ________________

Health History

Do you now or have ever had any of the following illnesses:

Y N Asthma
Y N Diabetes
Y N Seizures
Y N Wear Contacts
Y N Eye Problems
Y N Skin Disorders
Y N Respiratory problems
Y N Hay Fever
Y N Bowl problems
Y N Allergy to bee, wasp
Y N Heart Disease
Y N High Blood Pressure
Y N Migraine Headaches Y N
Y N Other: ________

Please explain any "YES". When did you have this illness? How severe? Are you being treated now?

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Current medications: name, dosage, how and when taken?

1. ________________ 2. ________________ 3. ________________

4. ________________ 5. ________________ 6. ________________

Surgeries: type and dates performed:

Allergic to medications/food? If YES, explain:

________________________ ________________________________
________________________ ________________________________
________________________ ________________________________

Other health information that you feel is important

________________________ ________________________________
________________________ ________________________________
________________________ ________________________________
________________________ ________________________________

Health Insurance

Company name ________________________ Phone number ________________

Account or Group #___ ________________ Insured number or ID # ________________

☐ I give my permission to the Health Coordinator for this trip to review this information.

Signed________________________________ Date ____________