



MEDICAL INFORMATION AND EMERGENCY CONTACT INFORMATION

Name on official ID/Drivers License/Passport: _____

Drivers Lic.# and State of issue / Other ID# / Passport number: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Home phone: _____

Work phone: _____ Email: _____

Blood type (if known): _____ Date of birth: _____

Local church affiliation: _____

1. Information about any prescriptions I use (include name and dosage): _____

2. I am allergic to: _____

3. Physical limitations or concerns: _____

4. Please provide other helpful health information: _____

5. Participant's physician: _____ Phone: _____

6. I consider myself healthy enough to fulfill my responsibilities on the Mission team: Yes No

7. I am diabetic: Yes No

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

IN CASE OF EMERGENCY, CONTACT THE FOLLOWING (PRIMARY CONTACT):

Name: _____ Relationship to missionary: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

UNABLE TO CONTACT THE ABOVE, CONTACT THE FOLLOWING (SECONDARY CONTACT):

Name: _____ Relationship to missionary: _____

Address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Email: _____

OTHER INFORMATION YOU WISH TO ADD IF AN EMERGENCY ARISES: _____

