Highland Oaks Church of Christ

Short-Term Mission Trip
Emergency Medical Information
REQUIRED --- must be completed!

NAME _____

ADDRESS _____

CITY _____ ZIP _____

AGE _____ DOB _____ PARENT'S NAME (if minor) _____

HOME PHONE _____ WORK PHONE _____

CELLULAR or OTHER # _____

DO YOU HAVE ANY CHRONIC DISEASES OR ALLERGIES? _____

IF YES, LIST: _____

DO YOU HAVE ANY PRE-EXISTING HEALTH PROBLEMS OR CONDITIONS? YES ☐ NO ☐

IF YES, EXPLAIN: _____

ARE YOU ALLERGIC TO ASPIRIN OR TYLENOL? YES ☐ NO ☐

ARE YOU CURRENTLY TAKING PRESCRIPTION MEDICATION? YES ☐ NO ☐

IF SO, WHAT & HOW OFTEN? _____

HAVE YOU HADE A TETANUS SHOT IN THE LAST 10 YEARS? YES ☐ NO ☐

WHAT IS YOUR BLOOD TYPE? _____

LIST ANY SLEEPING CONDITIONS YOU HAVE, (EXAMPLE: SNORING, INSOMNIA): _____

_____

Attach a copy of participant's medical insurance card

Family Physician: _____ **Phone #** _____

Insurance Company: _____ **Phone #** _____

Policy # _____ **Group #** _____

The information on this form will be kept confidential within the leadership of Highland Oaks Church of Christ

EMERGENCY CONTACT #1 *(Do not use people who will travel with you to the field.)*

Name: _____ Relationship to You: _____

Address: _____

City/State/Zip: _____

Telephone: HOME _____ WORK _____

E-Mail: _____

EMERGENCY CONTACT #2

Name: _____ Relationship to You: _____

Address: _____

City/State/Zip: _____

Telephone: HOME _____ WORK _____

E-Mail: _____

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