



## Medical Information & Authorization

Note: This form is to be completed for each **Participant**.

Mission Trip Date: \_\_\_\_\_

Group/Church Name: \_\_\_\_\_

Your Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

### For participants under the age of 18:

Parent/Guardian Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

**Medical Insurance Information:**

Insurance Company: \_\_\_\_\_

Insurance Company Phone: \_\_\_\_\_

Policy Number/Group Number: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Dentist's Phone: \_\_\_\_\_

**EACH PARTICIPANT MUST HAVE AN UP-TO-DATE TETANUS SHOT!**

Date of last Tetanus/Diphtheria Booster shot: \_\_\_\_\_

List all health problems, allergies, medications, and other pertinent information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Participant signature) (Print Name) Date: \_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian signature) (Print Name) Date: \_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian signature) (Print Name) Date: \_\_\_\_\_