LEGACY
MISSION INTERNATIONAL
BUILDING AN ETERNAL LEGACY

Emergency Medical Information

Name: ____
(Last) (First) (Middle Initial)

Gender: □ M □ F **Age**: ______ **Birth Date:** _______________

Parent's Name (if under 21): ____

Parent's Phone: ( ) _______________________ **Work:** ( ) __________________________

Blood Type: __________________ **Date of last Tetanus shot:** __________________

HEALTH INFORMATION (To be completed by all participants):

Check the following boxes (If "Yes" please explain):

□ Yes □ No Do you have any Drug Allergies? ____

□ Yes □ No Do you have any Food Allergies? ____

□ Yes □ No Do you have any Environmental Allergies? _____________________________________

□ Yes □ No Has any allergic reaction required emergency room care? _______________________

□ Yes □ No Do you have a Heart Condition? ____

□ Yes □ No Do you have High Blood Pressure? ____

□ Yes □ No Do you have any Respiratory Difficulties? ______________________________________

□ Yes □ No Are you diabetic? □ Diet Controlled □ Oral medication □ Insulin

□ Yes □ No Do you wear contact lenses?

□ Yes □ No Have you had any serious illness or surgery within the past three years? If so, list with dates

____

□ Yes □ No Have you ever been treated for anxiety, nervousness, or stress related disorders? If "yes" please explain.

____

Please indicate **ANYTHING** else that the leaders should know to help deal with any situation that might arise:

____

LIST ALL CURRENT MEDICATION, DOSAGE, AND WHAT IT IS BEING TAKEN FOR: __________________________

____

(Continue medications on the back if necessary)

EMERGENCY CONTACT INFORMATION (someone NOT with you on this trip): This MUST BE INCLUDED

Emergency contact: _______________________________ Relationship _____________________

Address: ____
(Street) (City) (State) (Zip)

Telephone: Home ( ) ___________________________ Work or Cell ( ) _________________________

Primary Physician: ( ) _______________________ Physician's Phone ( ) ________________________

In the event emergency medical aid/treatment is required due to illness or injury during the term of my short-term mission trip I authorize Legacy Mission International to:

1. Secure and retain medical treatment and transportation if needed.
2. Release the above provided information to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication, and any treatment procedure deemed necessary by a physician or other qualified medical personal. This provision will only be invoked if the person(s) above is unable to be reached.

_______________________________________ ______________________________
Signature Date