MEDICAL and EMERGENCY INFORMATION FORM

*(Team Leader should keep and carry original. A copy should be kept by the UMVIM Coordinator or local church until the missioner returns.)*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mission/Project Dates: | | | Mission Site/Location: | | | | | | |
| **Name** | | | | | | Birthdate | | | |
| Address | | | | | | Home Phone ( ) | | | |
| City | | State | Zip | | | Cell Phone ( ) | | | |
| Email | | | | | | | | | |
| Physician’s Name | | | | | Physician’s Phone ( )  Physician’s Afterhours Phone ( ) | | | | |
| Physician’s City/State | | | | | | | | | |
| Current Medications of Concern in an Emergency: | | | | | | | | | |
| Allergies (e.g. Food, Medications, Bee/Wasp Stings): | | | | | | | | | |
| Pre-existing medical conditions or physical disabilities: | | | | | | | | | |
| Medical Insurance Co. | | | | | | | | Phone ( ) | |
| Group | | | | | | | | Policy No. | |
| ***Please attach a copy of your insurance card (all missions), Driver’s License (US mission/out of state), and/or Passport (int’l mission).*** | | | | | | | | | |
| I |  | | | , authorize | | |  | | ***,*** |
|  | *(UMVIM participant)* | | |  | | | *(another adult on journey)* | | |

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Dawn Hawkins, Team Leader,

if I am unable to do so, to consent to any necessary examination, anesthetic, medical diagnosis, surgery treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which he/she practices, during the duration of the journey identified above.

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

(for youth under 18 parents must also sign Parental Consent Form)

**Notarization of Medical and Emergency Information Form executed in the presence of:**

STATE OF\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTY OF\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On this \_\_\_\_\_day of \_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_(year), before me personally appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To me known to be the same person(s) described in and who executed the within

instrument, and who acknowledged the same to be the free act and deed thereof.

Notary Public \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT DETAILS

**Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Contact Name** |  | **Relationship** |  |
| **Email Address** |  | **Cell Phone** |  |
| **Home Phone** |  | **Work Phone** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Alternate Contact Name** | |  | | **Relationship** |  |
| **Home phone** |  | | **Cell Phone** | **Work phone** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Alternate Contact Name** | |  | | **Relationship** |  |
| **Home phone** |  | | **Cell Phone** | **Work phone** |  |