St. Joseph Church – Mission of Hope
Medical Information for Adult Volunteers

Name _____ Date _____ Birth Date _____

Address _____ Blood Type _____

Emergency Name #1 _____ Phone # _____ Phone #_____

Relationship to Volunteer _____ Phone # _____ Phone #_____

Emergency Name #2 _____ Phone # _____ Phone #_____

Relationship to Volunteer _____ Phone # _____ Phone #_____

Insurance Carrier _____ Policy # _____

Allergies _____

_____

Medications and Dosages _____

_____

_____

Describe Any Medical Conditions/Limitations _____

_____

_____

_____

I consider myself healthy enough to fulfill my responsibilities on the mission team. **Yes** or **No** (circle one)

Date of last tetanus shot: _____

I am a diabetic: **Yes or No** (circle one) I have a history of seizures: **Yes or No** (circle one)

I, _____, authorize _____
Volunteer Signature Responsible Party
to consent to any necessary examinations, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered under the general supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which they practice, during the duration of the trip identified above and further authorize the release of medical information from my personal records for the following purpose:

_____

but do not give permission for any other use or re-disclosure on the information.