Adult Mission Volunteer
Health Information and Emergency Contact

Volunteer Name _____

Please indicate where you'll be volunteering:

Site: _____ Dates of Mission Trip: _____

Please complete the form below. The information will be kept in the strictest confidence. This is standard, but critical information for First Presbyterian Church of Saline to be able to protect you, your family and the ministry to the greatest extent possible. We want to make sure that if an emergency occurs, the correct knowledge and preparation is in place to properly care for you.

Name_____ Date of Birth_____

Address_____

City _____State _____Zip Code _____

Home phone _____ Cell phone _____

Family Doctor _____ Phone_____

Health Insurance Carrier_____ Contract No._____

Group No._____ Insurance Phone_____

Date of last Tetanus shot_____

Are you taking any medications at present? _____ Yes _____ No. **If "Yes"**, list medication, dose, freq.

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Medication _____ Dose _____ Frequency _____

Do you have any allergies: _____Yes _____No **If "Yes"**, list allergy and reaction.

Insect stings_____
Environmental_____
Food_____
Medication_____
Other_____
Are any medications or treatments helpful for allergy?
_____

Do you have asthma? _____Yes _____No **If "Yes"**, MUST have inhaler on the trip.

Do you have diabetes? _____Yes _____No

If "Yes", what is your treatment?_____

Please describe any health conditions Trip leader should be aware: (pacemaker, lifting restrictions, diabetic, heart ailments, rare blood type, recent injuries/surgeries, etc.)

_____

_____

Note: It is each participant's responsibility to bring needed / appropriate medications (i.e. EpiPens, insulin, inhalers and prescription medications) with you to the site. First Presbyterian Church of Saline cannot be responsible for these medications.

Please list who could be contacted on your behalf in case of emergency:

EMERGENCY CONTACT

Name_____

Address_____

City _____State _____Zip Code _____

Relationship to volunteer_____

Home phone _____ Cell phone _____

Authorization

I have provided this health information with knowledge of the conditions and activities contemplated during this mission trip. I have listed on this form all physical or emotional disabilities which would impair my participation. I am taking only the medication listed on this form and have no allergies known to me except as noted.

In the event of illness or injury, I authorize the physician and/or hospital to undertake such treatment of and perform such services (including surgical service) as are reasonably indicated by the circumstances.

Signature_____ Date_____