Name:	Date of Birth:	Age:
Address:	City:	State:
Gender:		Phone:
Health Insurance Company:		

Please staple a copy of your insurance card (front and back) to this form.

HEALTH INFORMATION: Checkmark whether you have/had or have not had the following conditions. Explain all "yes" answers.

YES	NO	CONDITION	EXPLAIN/SPECIFY
		Asthma Last attack was _____/_____/_____	
		Diabetes _____(Type 1) / _____(Type 2) _____ (Gestational)	
		Hypertension (high blood pressure)	
		Hypoglycemia (Heart condition or disease/heart attack/heart murmur/etc. low blood sugar)	
		Stroke	
		Lung disease or respiratory disease	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological/emotional/anxiety difficulties	
		ADD/ADHD or behavioral disorder	
		Blood disease or bleeding disorders	
		Fainting spells Last incident was _____/_____/_____	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures Last seizure was _____/_____/_____	
		Sleep disorders (e.g. sleep apnea) Use CPAP? Yes ____ / No ____	
		Abdominal/digestive disorders (e.g. ulcer, celiac, etc.)	
		Excessive fatigue or shortness of breath with exercise	
		Genetic condition	
		Neurological disorder	
		Other:	

Please list and explain ALL major illnesses/injuries, surgeries, and hospitalizations you have experienced (attach sheet, if needed):

___I have had NO serious illnesses or surgeries and have NEVER been hospitalized.

ALLERGIES: Checkmark whether you have/had or have not had adverse reactions to the following. If yes, be specific about your allergy.

YES	NO	ALLERGEN	EXPLAIN/SPECIFY
		Medication	
		Food	
		Plants or Insect bites	
		Latex	
		Other:	

Do you carry an Epi-pen for allergies? Yes ____ / No ____. If so, have you used an Epi-pen in the last year? Yes ____ / No ____

Date of last Tetanus shot:_____. (Tetanus immunization within the last 10 years is highly recommended prior to the trip.)

MEDICATIONS: Adults and minors who use medications to treat a condition must complete this section. List all medications currently being used, including those carried for emergencies (inhaler, Epi-Pen…). Complete all sections for EACH medication that you take.

___ I use NO medications

MEDICATION NAME	REASON FOR MEDICATION	STRENGTH	DOSAGE & FREQUENCY

Parent/Guardian Note: In the case of a minor, all medications, prescription or not, must be in *the original container with label and participant's name*.

EMERGENCY CONTACTS: List 2 people who you consent for us to call in case of an emergency (for minors, 1 must be a parent/guardian).

1. Contact Name:	Relationship:
Phone Number (Home):	Phone Number (Cell):
2. Contact Name:	Relationship:
Phone Number (Home):	Phone Number (Cell):

Please provide details regarding any physical/psychological illness or disability that may affect your work.

List any anxieties/fears that the team leader should be aware of (i.e. closed in spaces, crowds, etc.).

List any concerns you have about working for eight hours, doing manual labor, such as lifting and moving objects? If none, please enter "none".

Have you experienced any problems with heights?

Do you get dizzy or lightheaded easily?

Medical consent giving permission to seek whatever medical attention is deemed necessary in case of injury.

- In the event of an illness, injury, or emergency that requires treatment during the duration of the trip, I hereby give consent to a licensed physician to secure and provide proper treatment which could include hospitalization, anesthesia and/or surgery for me or my child.
- In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person and BPC free and harmless of any claims, demands, or suits for treatment/damages/injuries arising from the giving of such consent.
- I/We also acknowledge that I/we will be ultimately responsible for the cost of any and all medical care. Further, I/we affirm that the health insurance information provided is accurate at this date and will still be in force for the Mission Trip participant.
- By signing below, I/we agree to the terms of the medical consent.

Participant Signature: _____ Date_____

Parent/Guardian Signature (for minors) _____ Date_____