Greene County Baptist Association, Mission trip to Guadalajara, Mexico

MEDICAL INFORMATION FORM

PLEASE PRINT CLEARLY

Name ____Date of Birth ____________

Address ____

Telephone _________________________ Cell # ______________________________

Member of what Church? ____

Other Insurance: Company ____

Group # or name _______________________________________

Policy # ____

Someone to notify case of emergency: Name __________________________________

Relationship ___________________________________

Day Time Phone __________________Night Telephone __________________

Medical History ____

____

Allergies: ____

Blood Type: ____

Medications now taking: ____

Family Doctor name:______________________________ Phone ______________

I hereby authorize release of this information to any physician, hospital, or clinic as needed for my medical care and/or in case of accident or emergency.

Signature: ____________________________________ Date: __________________