Our Savior's Lutheran Church
809 S. Commercial Street,
Neenah, WI 54956
(920) 725-3956
ashepeck@our-saviors.org

Missions

GO AND DO LIKEWISE LUKE 10:37

YOUTH VOLUNTEER MEDICAL INFORMATION FORM (under 18)

Name of Youth Volunteer:_____

Please print. A completed medical information form is required for all participants attending this event.

Address_____

Date of Birth _____/_____/_____ **Age**_____ **Blood Type** _____

Person to be contacted in case of emergency

_____

Relationship_____ **Phone** (_____)_____ **Alt. phone** (____)_____

Alternate Contact_____(_____)_____

Doctor's Name_____ **Phone** (___)_____

Doctor's Address_____

Health Insurance Co._____ **Policy #**_____

Do you wear glasses/contacts? (circle one) Yes No

Eye Doctor's Name: _____ **Phone** _____

Dentist's Name: _____ **Phone** _____

Do you wear dentures/partial plates? (circle one) Yes No

List any medication you will be taking during the trip.

_____

_____

Do you have any medical conditions or limitations?

_____

_____

Special Needs

_____

_____

-over-

Please answer <u>yes or no</u> to the following items:

Have you ever been treated for: (If currently being treated, please indicate)

A. Nervousness _____
B. Any Mental Disorder _____
C. Convulsions or Epilepsy _____
D. Fainting Spells _____
E. Heart Condition _____
F. Rheumatic Fever _____
G. Cancer or Tumor _____
H. High Blood Pressure _____
I. Severe or Frequent Headaches _____
J. Asthma _____
K. Ulcers _____
L. Diabetes _____
M. Allergic Reaction to Medication _____
N. Any Other Allergies or Illnesses _____

Give details of yes answers to any of the questions above. Give dates of treatment, and names and addresses of attending physicians, hospitals and clinics. *(Use reverse side if necessary.)*

PLEASE READ CAREFULLY

Disaster relief trips can be hazardous. You can be exposed to mold, dust, heat, humidity, and other dangers. Please carefully consider these factors when deciding to participate if you have asthma, allergies, or lung problems. We will accommodate anyone we can when planning tasks, but can only do so with complete and correct medical information. We reserve the right to require a physician's approval before attending.

The information you submit will be used only for this Mission Trip to Mississippi. After your trip all Medical Forms will be destroyed. We would appreciate that you complete as much as you can so that medical attention to you will not be delayed for any reasons. Thank you.

PLEASE READ CAREFULLY

I hereby certify that the information given above is complete and correct. In case of medical emergency, I understand that every effort will be made to contact the person designated above. In the event that the aforementioned contact person cannot be reached, or time does not permit, I hereby give permission to a licensed physician to provide proper treatment, including hospitalization, immunization or injection, anesthesia or surgery.

Signature of
Parent or Guardian_____ **Date**_____