



GRACE COMMUNITY CHURCH

SPREADING THE FAME AND GLORY OF GOD'S NAME AMONG ALL PEOPLE

MEDICAL INFORMATION SHORT-TERM MISSIONS PROJECT

PLEASE PRINT

(FIRST NAME)

(LAST NAME)

I. HEALTH

CONDITION OF HEALTH: EXCELLENT GOOD FAIR POOR

List any chronic ailments _____

Explain any emotional or physical disabilities or limitations: _____

II. MEDICAL INSURANCE

My current health insurance policy **DOES** cover the trip.

INSURANCE COMPANY _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Policy Number: _____

My current health insurance policy **DOES NOT** cover the trip to _____.

III. PERSONAL PHYSICIAN

PHYSICIAN'S NAME _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

IV. MEDICAL STATUS

Complete the information below if you think it would be beneficial for the team leader or a physician in the host country to be informed of medication you are currently taking.

MEDICATIONS YOU ARE TAKING	DOSAGE	REASON
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Describe any special medical considerations (allergies, asthma, special diet, etc.)

V. MEDICAL RELEASE

I give my consent to the properly appointed staff of the sponsoring agency to secure the administration of medical treatment or medication for myself in case of emergency, and I do further agree to the performance of such treatment, anesthetics, and operations, that in the opinion of the attending physician are deemed necessary for myself.

Signature _____ Date _____

VI. NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Fax (____) _____

E-Mail _____

Signature _____ Date _____