EMERGENCY MEDICAL INFORMATION FORM

Your Name_____ Date of Birth_____

Address_____
(Street) (City) (State) (Zip)

Home Phone(_____)_____Work Phone(_____)_____ E-Mail_____

Emergency Contact Person:_____ Relation to You:_____

Their Daytime Phone(_____)_____Their Evening Phone(_____)_____

HEALTH INSURANCE COMPANY INFORMATION_____

Company Name_____Phone(_____)_____

Insurance ID Number_____ Group Number_____ Physicians Name_____

Physicians Clinic_____Clinic Phone(_____)_____ __Dr.Phone(_____)_____

HEALTH HISTORY_____

Please list any medical condition(s)/disease(s)/allergies for which you are being treated:_____
_____
_____

Please list all prescription medications and dosages you are currently using:_____
_____
_____

Please describe any medical equipment you will be taking:_____
_____
_____
_____

VACCINATIONS_____

Vaccine	Dates given		
Tetanus			
Typhoid			
Hepatitis A			
Hepatitis B	1st	2nd	3rd
Malaria			

It is not the responsibility of Living Word Christian Center to cover any medical expenses you may incur while on this trip; however, the information you submit can help provide you with the proper medical care in the event it is needed. By signing below you are agreeing to be financially responsible for the expense of any medications, medical services and/or procedures which may be incurred on this trip.
Please sign, date, and return this form as quickly as possible to assist us in administrating this trip. You signature acknowledges to us that you are submitting complete and accurate information so that we may better serve you.

Signature_____
Date_____