20\_\_ RANCHO SANTA MARTA MISSION TRIP ADULT PARTICIPANTS MEDICAL RELEASE & AUTHORIZATION FORM (CONFIDENTIAL INFORMATION FOR USE IN MEDICAL EMERGENCIES)

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_ Last Tetanus Shot: \_\_\_\_\_\_\_\_\_\_

Name of Your Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all the medications you are presently taking indicating the generic name, exact strength and dosage.

Click here to enter text .

List medical problems for which you have received medical care in the past 12 months:

Click here to enter text .

List any history of major illness or surgery:

Click here to enter text

List any known allergies (including food allergies) or chronic life-threatening conditions:

Click here to enter text.

Please list any medical conditions helpful for a physician to know should you require emergency medical attention during the trip:

Click here to enter text.

Describe your present physical fitness (e.g., walking, manual labor, heavy lifting, carrying luggage)

Click here to enter text .

EMERGENCY AUTHORIZATION I give any licensed, practicing physician or hospital full authority to provide emergency medical treatment for me in the event such treatment is needed or necessary and I am not able to make such a decision. I also hereby give my permission for a licensed practicing physician to administer whatever medical treatment he/she may deem necessary for me in the event of any medical emergency affecting me.

IN CASE OF EMERGENCY CONTACT: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_