Williams Neighborhood Chirch

2024 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 #: _____________________________

Do you have proof of Vaccination for COVID? ____________________

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

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

List any history of major illness or surgery:

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

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

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

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: ___________________________