

**Mississippi Conference
United Methodist Church**

**MEDICAL INFORMATION
FOR INDIVIDUAL VOLUNTEERS
(Every Volunteer Needs to Fill Out This Form)**

Please complete the following and give to mission leader. MISSION TEAM LEADER SHOULD RETAIN THIS FORM ON SITE TO USE IN CASE OF EMERGENCY.

Name _____ Dates of mission trip _____

Blood type _____

Information about any prescriptions I use:

I am allergic to: _____

Name of contact person _____

Street Address _____

City _____ State _____ Zip _____

Phone (work) _____ (Home) _____

Relationship to volunteer _____

My health insurance company is _____

Policy number _____

Physical limitations or concerns:

I am diabetic: Yes _____ No _____

I have a history of seizures: Yes _____ No _____

Please provide other helpful health information:

I consider myself healthy enough to fulfill my responsibilities on the mission team. Yes _____ No _____

I, _____ (volunteer's signature), authorize _____ (team leader) to consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered under the general supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which they practice, during the duration of the trip identified above and further authorize the release of medical information from my personal medical records for the following purpose: _____ but I do not give permission for any other use or re-disclosure of this information.