

Faith Communities For Disaster Recovery

MEDICAL INFORMATION FORM (Youth) Faith Communities for Disaster Recovery

Please complete the following and give to mission team leader:

I, _____ authorize _____
(Parent or legal guardian of volunteer participant) (another adult on trip)
to consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered to him/her under the general or special 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 below.

Trip or Activity: _____ Volunteer work with Faith Communities for Disaster Recovery _____

Dates of Trip: _____

Participant's Physician: _____ Telephone: _____

Allergies and Medications: _____

Participant's Medical Insurance: _____ / _____
(Carrier) (Policy Number)

Carrier's Telephone Number: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Witness: _____

Signature of Participant: _____ Date: _____

Social Security Number: _____

Witness: _____