



MEDICAL INFORMATION FORM
THIS FORM IS FOR INDIVIDUAL VOLUNTEERS

(EVERY VOLUNTEER IS REQUIRED TO FILL OUT THIS FORM BEFORE WORK ASSIGNMENTS)

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 _____ Age _____ Dates of mission trip _____

1. Blood type _____
2. Information about any prescriptions used: _____
3. List any known allergies: _____
4. Name of contact person(s): _____
5. Street Address _____
 - a. City _____ State _____ Zip _____
 - b. Phone (Work) _____ (Home) _____
 - c. Relationship to volunteer _____
5. My health insurance company: _____ Telephone _____
Health Policy Number: _____
6. Physical limitations or concerns: _____
7. I am diabetic: Yes _____ No _____
8. I have a history of seizures: Yes _____ No _____
9. Please provide other helpful health information: _____

10. I am healthy enough to fulfill my responsibilities on the mission team. Yes ___ No ___



The East Biloxi Coordination, Relief & Redevelopment Agency
COORDINATION CENTER

I, _____ authorize _____
Volunteer Signature *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:

____ **I do not give permission for any other use or re-disclosure of this information.**

Signature Print

Witness Title