Short Term Missions Program

Emergency Health Information

Information provided on this form will be kept in confidence and only accessed in case of emergency on a mission trip.

Name: _____ Date: _____

Do you have any particular health problems, diseases, or physical limitations? YES NO

Have you had any serious illnesses in the last five years or been under the ongoing care of a doctor in the last year? YES NO

If yes, please describe:

Do you have any chronic allergies? YES NO

If yes, please list any allergies and how you typically treat them:

Are you allergic to any medications? YES NO

If yes, please list any medications allergies:

Please list ALL medications you take on a regular basis, including dosages and frequency:

Do you have health insurance? YES NO

Name of Company: _____

Policy Number: _____