Orphans EMBRACE
Louisiana Baptist Children's Home & Family Ministries

Medical Health Questionaire

TRIP LOCATION: _____Haiti_____ TRIP LEADER: _____
TRIP DATES: October 2-8, 2021

Participation on a mission trip or project requires good health and physical stamina. It is recommended that you have a physical examination before participating on a mission trip or project. You should also consult with your physician if you are under his care or you are regularly taking medication.

Name: _____ Date Of Birth: _____
Last First Middle Initial Month/Day/ Year

Address: _____
Address City State/Province Zip/Postal Code

Sex: Male Female Height: _____ Weight: _____ Blood Type: _____ SS#: _____

In Case of Emergency, Notify: _____
Name Relationship

_____ ___(_____)_____
Address City State/Province Zip/Postal Code

1. Have you ever suffered a serious illness, had surgery performed, or been hospitalized? ____YES ____NO

   _____

2. Do you have any known allergies? ___YES ____NO Please explain

   _____

3. Do you have any dietary restrictions, food allergies, or convictions regarding types of food? ____YES____NO

   _____

4. Are you currently taking any medications? Include prescription and non-prescription drugs, Dietary supplements, herbs, etc. _____YES _____NO Please explain

   _____

5. Are you currently receiving medical treatment or under medical observation for anything? ___YES____NO

   _____

6. Have you ever been treated for (or are now suffering from) emotional difficulties? (eating disorders, depression, anxiety, phobias, etc) _____YES _____NO Please explain

   _____

7. Are you seeing a counselor or therapist? ____YES _____NO Please explain

   _____

8. Do you have a communicable disease? _____YES _____NO Please explain

_____

9. Do you have any chest, back, or joint pain? _____YES ____NO Please explain

_____

10. Do you have any limitations to strenuous physical work? _____YES ____NO Please explain

_____

11. Do you have any other limitations or significant health conditions which might affect your involvement on the mission trip or which you believe your physician would want us to know about? ____YES _____NO Please explain:

_____

IMMUNIZATIONS: For our information, please indicate date of most recent immunizations.

Tetanus_____ Diphtheria _____
Measles/Mumps/ Rubella _____ Poliomyelitis _____

Physician's Name: _____ Office Phone: _(___)_____

MEDICAL PROFILE:

Generally, Participant's Health is (Check One) ___Excellent ___Good ___Fair ___ Poor
If Fair or Poor, please explain your condition: _____
_____

MEDICAL INSURANCE INFORMATION:

Insurance Company: _____ Policy #: _____
Subscriber Name: _____ Subscriber #: _____
Place of Employment: _____

EMERGENCY MEDICAL PERMISSION: This is only for emergency situations should the individual being incapable of making rational decisions, or is a minor whose parents cannot be immediately reached. In any situation, every effort will be made to reach the person to contact listed on the application.

In the event that an emergency arises, I give the trip leader permission to authorize anesthesia, surgery, and/or procedures deemed absolutely necessary at the time.

_____ _____
NAME OF APPLICANT (please print) Signature (of applicant if age 18 or older)

NOTE: Parent or Legal Guardian's signature if you are single and under 18 (or under 19 and reside in AL, NE, WY; or under 21 and reside in CO, MS, WV, PA PR).

_____ _____
Parent or Legal Guardian Relationship