

# Hope Fellowship Medical Information

Name \_\_\_\_\_ Age (if under 18) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy /Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ (if different than above)

Policy Holder's Employer \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

Guarantor Name (if different from Policy Holder) \_\_\_\_\_

Address \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of last Tetanus shot \_\_\_\_\_

List any major illnesses within the past year \_\_\_\_\_

List any medications you take regularly \_\_\_\_\_

**NOTE:** Be sure to take an ample supply of prescriptions for the length of any trip taken with Hope Fellowship. Provide your Group Leader with a written prescription from your doctor for any medication you will be taking during any overnight trip!

List those things to which you are allergic \_\_\_\_\_

List any physical disabilities or current health issues \_\_\_\_\_

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## ***In case of emergency, please contact:***

Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Relationship \_\_\_\_\_ Mobile Phone # \_\_\_\_\_

Address \_\_\_\_\_ Work Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_  
*Parent's/Guardian Signature*

\_\_\_\_\_  
*Date*

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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## ***For Your Doctor***

I have examined \_\_\_\_\_ and find him/her to be in good general health and physically able to take part in a Hope Fellowship Church trip or activity. Conditions that Hope Fellowship should be aware of are:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Doctor's Signature*

\_\_\_\_\_  
*Date*