# 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: ______________________

***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*