



## Mission Team Medical Information Form

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**Personal Information:**

Name \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**Medical History:**

Allergies: \_\_\_\_\_

Medical issues: \_\_\_\_\_

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**Current Medications (list dose and frequency):**

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Blood Type (if known): \_\_\_\_\_

**Emergency contact:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Cell: \_\_\_\_\_ Home: \_\_\_\_\_ Other: \_\_\_\_\_

\*This information **is not** required for your mission trip but may be supplied by you on a voluntary basis. It is kept confidential and will only be used in case of a medical emergency. Only your team leader and/or Northplace staff member supervising your mission trip will have access to your information.