Confidential Health Questionnaire

To provide for your health care needs and assure your medical safety, your team leader will bring your completed form to use as a reference should you require medical attention. We need your honest answers to the following questions. This information will remain completely confidential and will be shredded upon return from the mission trip.

Trip Destination _____ **Trip Dates** _____

Name _____ DOB _____ /_____ /_____

Family Doctor Name _____ Phone # _____ /_____ /_____

Doctor Address _____

Health Insurance Company _____

Policy Number _____ Phone # _____

General Physical Health Profile Blood Type *(If Known)* _____

- ❑ Great — no prescriptions or physical limitations.
- ❑ Good — minor prescription needs and/or little physical limitations.
- ❑ Fair — moderate prescription needs and/or minor physical limitations.
- ❑ Reduced — major prescription needs and/or moderate to limited physical mobility.

If medications are taken, team member must make sure that they have enough to cover the whole trip length and are stored in the bottle they came in. Please list current prescription medications

_____

_____

If you have physical limitations, please describe problem(s) and measures taken to relieve the problem(s) other than medications

_____

_____

_____

If you have any allergies, please list them and any reactions to watch for or that need treatment

_____

_____

Signature: _____ **Date:** _____

Printed Name: _____