



SENSITIVE

Saint Paul Catholic Church

Medical Information, Authorization & Release

No Missionary will be allowed to participate in the Honduras Mission Trip without having submitted this medical information and authorization form.

Activity Description

Please provide, by _____ (due date), the following information to assist Saint Paul Catholic Church (“the Church”) in providing for the health and safety of Missionary during his or her participation in the Honduras Mission Trip, which will include one or more of the following Church activities:

- | | |
|-----------------|-------------------------|
| a. Construction | b. Medical |
| c. Dental | d. Distribution of Food |

1. Missionary Information

Missionary: _____
First Name Middle Name Last Name

Street Address: _____

City, State ZIP: _____

Date of Birth: _____ Age: _____ Gender: Male Female Blood Type: _____

2. Parent or Guardian Information

Complete if Missionary is under 18 years of age; if contact information is the same as that for Missionary, write “same”.

Father/Guardian: _____
First Name Middle Name Last Name

Address: _____

Phone: H _____ W _____ C _____

Email : _____

Mother/Guardian: _____
First Name Middle Name Last Name

Address: _____

Phone: H _____ W _____ C _____

Email : _____

SENSITIVE

3. Emergency Contact (if parent/guardian cannot be reached)

Name: _____

Relationship to Missionary: _____

Phone: H _____ W _____ C _____

Email : _____

4. Doctor

Primary Care Physician: _____

Phone: Office _____ Cell _____

Email: _____

5. Health Insurance

Missionary's Health Insurance Company Name: _____

Address: _____

Policy Number: _____ Effective Date of Coverage: _____

Phone: _____

6. Allergies

Please describe the Missionary's allergies and allergic reactions (including allergies to medications and natural substances):

7. Immunization Record

Please provide Missionary's immunization record and dates (including dates of basic immunization and last booster). Immunizations marked with an * are specifically required to participate in Mission Honduras.

Polio		* Tetanus	
Measles		Mumps	
Rubella		DPT/TD	
* Hepatitis A		* Hepatitis B (health care providers only)	
Acellular Pertussis		TB test given	

SENSITIVE

8. Special Limitations

Please note any special limitations of Missionary's ability to participate fully in the activity described above that are caused by any physical, mental, or medical condition:

9. Current Medications

Please list all current medications that Missionary takes:

Medication	Dose	Frequency

10. Special Dietary

Please list any special dietary requirements of Missionary.

11. Illnesses

Does Missionary currently have any of the following illnesses?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy (Seizures) | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other (Please elaborate below) | |

Please describe any of the above illnesses or any other illness or disease that Missionary currently has, and any communicable disease or illnesses that Missionary has had during the last six weeks:

12. Injuries

Has Missionary ever had, or does Missionary currently have any of the following injuries?

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Sprained Back | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Recurrent Ankle Injury | <input type="checkbox"/> Recurrent Knee Injury | <input type="checkbox"/> Other: _____ |

Please describe any of the above injuries that Missionary currently has or has ever had:
