

SERVANT'S HEART JAMAICA, INC



MEDICAL INFORMATION FORM

NAME : AGE: M/F
ADDRESS: PHONE:
CITY: ST: ZIP:
INSURANCE CO.: POLICY NUMBER:
POLICY HOLDER:
ADDRESS (if different):
POLICY HOLDER'S EMPLOYER: PHONE:
GUARANTOR (if different from policy holder)
ADDRESS: PHONE:
DATE OF LAST TETNUS SHOT:
MAJOR ILLNESSES:
SURGERIES AND DATES:

PHYSICAL DISABILITIES OR CURRENT HEALTH ISSUES:
REGULAR MEDICATIONS:

Note: Be sure to take ample supply (2x) for your length of service and travel days

ALLERGIES: FOOD RESTRICTIONS:

EMERGENCY CONTACT: PHONE:

FOR YOUR DOCTOR

I have examined _____ and find him/her to be in good health and physically able to take part in a Servant's Heart Jamaica trip.

Doctor's Signature **Date:**

Parent/Guardian Signature **Date:**