

The Global Hands of Healing, Inc.
Medical/Dental Mission Team
Medical Information Form

Name: _____

Address: _____

City, State, Zip: _____

Phone : _____ (home) _____ (cell)

1. Blood type (if known): _____

2. Corrective Lenses: Yes No Contacts/Glasses (circle one)

3. List all medications currently being taken:

4. List all allergies:

5. Name of emergency contact in U.S. _____

Address: _____

City: _____ State: _____

Phone: _____ (H) _____ (C)

Relationship: _____

6. Health Insurance Company: _____ Policy#: _____

7. List any physical limitations or concerns:

8. Check all of the following that apply:

Allergies___	Asthma___	Diabetes___
Heart Disease___	Seizures___	Pregnant___
Lung Disease___	Kidney disease___	Food allergies___

List any other chronic medical condition:

List any special diet requirements: