

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

Medical Information Form

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ (home) _____ (work)

1. Blood type: _____

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) _____ (W)

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: