IN CASE OF AN EMERGENCY

GENERAL INFORMATION:

Last Name | First Name: | Middle Name:

Blood Type: | Age: | Gender: ☐ Male ☐ Female

Height: | Weight: | Eye Color: | Hair Color:

Eye Glasses: ☐ Yes ☐ No | Contact Lenses: ☐ Yes ☐ No | Pacemaker: ☐ Yes ☐ No | Dentures: ☐ Yes ☐ No

Birthmarks or Scars/Location:

OTHER PERSONAL INFORMATION:

Address: | City: | State: | Zip:

Home Phone: | Mobile Phone: | Email:

Passport number: | Issuing agency: | Exp. Date:

PHYSCIAN(S):

Primary Care Doctor:

City/State/Country:

Phone Number:

Emergency Service:

Specialist (Identify type):

City/State/Country:

Phone Number:

Emergency Service:

HOSPITAL (If necessary, transport me to the following hospital):

Preferred Hospital:

City/State/Country:

Phone Number:

Emergency Service:

INSURANCE:

Primary Carrier:

Phone Number:

Policyholder's Name:

Pre-Certification Phone:

Policy Number:

Group Number:

Secondary Carrier:

Phone Number:

Policyholder's Name:

Pre-Certification Phone:

Policy Number:

Group Number:

EMERGENCY CONTACT(S):

In Home Country:

Name:

Relationship To You:

Phone Number(s):

Email Address:

In Service Country (if applicable):

Name:

Relationship To You:

Phone Number(s):

Email Address:

Name:

Relationship To You:

Phone Number(s):

Email Address:

Please list additional contact persons (pastor, organization, friend, etc.) on separate sheet.

OTHER PERTINENT DOCUMENTS/INFORMATION (If applicable, attach document to sheet):

Living Will: ☐ Yes ☐ No

Do Not Resuscitate: ☐ Yes ☐ No

Organ Donor: ☐ Yes ☐ No

Medical Power of Attorney:

Phone Number(s):

Do you have an advanced health care directive? ☐ Yes ☐ No

If yes, can FRM have a copy in case of an emergency? ☐ Yes ☐ No

MEDICAL ALLERGIES (Food & Medicine)

Allergic to: Reaction:

Allergic to: Reaction:

Allergic to: Reaction:

Please list additional allergies on a separate sheet.

CHRONIC MEDICAL CONDITIONS

(Identify i.e. Cancer, Congestive Heart Failure, Diabetes I or II, Epilepsy, Seizures, Kidney or Liver Disease, etc.):

Condition: Date Diagnosed:

Specialist: Phone Number:

Condition: Date Diagnosed:

Specialist: Phone Number:

Please list additional chronic conditions on a separate sheet and attach.

OTHER MEDICAL CONDITIONS

(Identify i.e. Hearing Loss, Blindness, Anemia, Thyroid Disease, High Blood Pressure, etc.):

Condition: Date Diagnosed:

Specialist: Phone Number:

Condition: Date Diagnosed:

Specialist: Phone Number:

Please list additional medical conditions on a separate sheet and attach.

MANDATORY VACCINATIONS:

Tetanus/Diphtheria:

Yes No Date:

Meningitis Vaccine:

Yes No Date:

Hepatitis A:

Yes No Date:

Hepatitis B:

Yes No Date:

Typhoid:

Yes No Date:

Yellow Fever: Y / N Date:

Yes No Date:

Polio:

Yes No Date:

Name of Malaria Medicine:

Date:

CURRENT PRESCRIPTION MEDICATIONS:

Medication:

Usage:

Dosage:

Possible side effects:

Medication:

Usage:

Dosage:

Possible side effects:

Medication:

Usage:

Dosage:

Possible side effects:

Medication:

Usage:

Dosage:

Possible side effects:

Medication:

Usage:

Dosage:

Possible side effects:

Medication:

Usage:

Dosage:

Possible side effects:

Please list additional medications, dosage, and usages on a separate sheet and attach.

PHYSICIAN REVIEW:

I have reviewed the above medical information. As their physician, I recommend that this patient is: ☐ fit ☐ not fit to travel overseas and able to perform activities involved in the mission trip.

Physician Signature

Date

Physician Name - Please Print

AUTHORIZATION:

This information is correct to the best of my knowledge and I authorize Far Reaching Ministries or their representative to use this information in case of an emergency.

Signature

Date

This form is for my child under age 18. Permission is granted to treat my child in an emergency.

☐ Yes ☐ No, contact me prior to treating.

Parent Name:

Emergency Phone Number:

Parent Signature:

Date: