

# Medical History Form

## 2023 European Leadership Forum Short-Term Mission Trip

Please note that you'll need to provide information regarding your health insurance coverage, as well as your medical and vaccination history. You may wish to have these records on hand before you begin. All volunteers must fill out this form.

Name:

Email:

### Emergency Contact Information

Name:

Relationship to volunteer:

Primary Phone:

Primary Phone Type:      Home      Mobile      Work

First Additional Phone:

First Additional Phone Type:      Home      Mobile      Work

Second Additional Phone:

Second Additional Phone Type:      Home      Mobile      Work

Email:

## **Insurance Information**

I am:      American      European

Please provide the details of your insurance policy that the Forum would be required to provide on your behalf in the event of a medical emergency:

Name of insurance company:

Name of the policyholder:

Policy number:

Group number:

Name of family physician:

Physician contact information:

## **Personal Health Condition**

Do you have any allergies?

Do you have any chronic illnesses or medical conditions?

Are you on any medications? If so, please name them and briefly describe why you take them:

Have you had any serious injuries or operations in the past 10 years? If so, please name them:

Do you have any activity restrictions? If so, please name them:

## Medical History

Please indicate whether or not the following items appear in your medical history by selecting “yes” or “no”. If “yes”, **please provide dates and details.**

History	Yes or No	Dates and Details
Asthma		
Bleeding/Clotting Disorder		
Cancer		
Chicken Pox		
Convulsion/Epilepsy		
COVID-19		
Diabetes		
German Measles		
Heart Disease/Defect		
Hypertension		
Measles		
Mononucleosis		
Mumps		

## Vaccination History

Please obtain a record of your immunizations from your doctor. If this is a possibility, please check this box to indicate that you will obtain the record and send it in along with your Medical History form:

Alternatively, you can fill out your vaccination history below. Please indicate whether or not you have been vaccinated for each of the following by selecting “yes” or “no”. If “yes”, **please provide dates and details.**

Vaccine	Yes or No	Dates and Details
Chicken Pox		
COVID-19		
DPT		
German Measles		
Measles		
Mumps		
TD		
Tetanus		
Tuberculosis Test		

Is there anything else you'd like us to know?