SUMMIT
CHURCH

## Patient Information

Name: ______________________________________________
*Last* *First* *MI* *Date of Birth*

Address: ______________________________________________
*Street Address*

______________________________________________
*City* *State* *ZIP Code*

Home Phone: ____________________ Cell Phone ____________________

Emergency Contact: ______________________________________________
*Name/Relationship* *Address* *Phone Number*

Occupation: ______________________________________________

Mission Trip Location: ______________________________________________

## Medical and Health History

| | `YES | NO | If Yes, Explain: |
|---|---|---|---|
| Allergies: (Insect, food, environmental, medication) | ☐ | ☐ | |
| Vision Disorder: | ☐ | ☐ | |
| Hearing Disorder: | ☐ | ☐ | |
| Respiratory Illness: | ☐ | ☐ | |
| Asthma: | ☐ | ☐ | |
| Cardiac Disorder: | ☐ | ☐ | |
| Gastrointestinal Disorder: | ☐ | ☐ | |
| Orthopedic Condition: | ☐ | ☐ | |
| Neurological Disorder: | ☐ | ☐ | |
| Dizziness or Fainting: | ☐ | ☐ | |
| Skin Disorder: | ☐ | ☐ | |
| Thyroid Disorder: | ☐ | ☐ | |
| Diabetes Mellitus: | ☐ | ☐ | |
| Anxiety or Depression: | ☐ | ☐ | |

Female Only: Are you pregnant or suspect that you may be pregnant? Yes ☐ No ☐

Surgeries: ______________________________________________

______________________________________________

## Medication

Please list all current medication (both prescription and over the counter medications):
(Use separate sheet if necessary)

***Name of medication*** ***Dosage, frequency*** ***Reason for taking medication***

Do you have any health problems that might be affected by the living conditions, rigorous schedule and demanding workload of this trip? Yes ☐ No ☐
If Yes, Please explain: ______________________________

Do you have any special dietary needs? Yes ☐ No ☐
If Yes, Please explain: ______________________________

## Immunizations

Please list date of last Tetanus vaccination: ____________________

Routine vaccinations are recommended.

Other recommended vaccinations may include: Hepatitis A, Hepatitis B, Malaria and Typhoid.

Please go to the Centers for Disease Control and Prevention (CDC) Travelers' Health website for destination specific vaccination recommendations: https://wwwnc.cdc.gov/travel/destinations/list/

Do you agree to inform your team leader and missions director as soon as possible if any of these answers would change before your trip departure date? Yes ☐ No ☐

*I certify that the above statements and answers are complete and true to the best of my knowledge.*

PARTICIPANT'S PRINTED NAME ______________________________

PARTICIPANT'S SIGNATURE ______________________________

DATE: ____________________

## Physical Examination

***TO BE COMPLETED BY A MEDICAL PROVIDER***

Height _______ Weight _________ B/P _____________ Pulse ____________ Vision _________________________
(Corrected/Uncorrected)

| | NORMAL | ABNORMAL | COMMENTS |
|---|---|---|---|
| Skin | | | |
| HEENT | | | |
| Neck | | | |
| Cardiac | | | |
| Lungs | | | |
| Abdomen | | | |
| Back | | | |
| Extremities | | | |
| Neurological | | | |
| Mental Status | | | |

Are there any medical problems, chronic disease, or medications which require restriction of activity or affect his/her role? If so specify:

_____________________________________________________________________________________

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I certify that I have reviewed the health history and performed a comprehensive physical examination and based on my evaluation:

☐ Find no medical condition or physical impairment that precludes participation in a medical mission trip.

☐ Do not recommend participation in a medical mission trip due to: ____________________________________

Medical Provider Name: ___________________________________________ License Number: ________________________

Address: ________________________________________________________ Phone Number: __________________________

Signature: ______________________________________ MD, DO, NP, PA-C (circle one) Date: ______________________