

LINC-Houston

Date: _____

EMERGENCY MEDICAL INFORMATION FORM

NAME: _____ SS#: _____

HEALTH PLAN CARRIER: _____

POLICY# _____

HEALTH PLAN PHONE # FOR CONFIRMATION: _____

General: Does participant have: (if "yes" please explain)

YES NO ALLERGIES:

YES NO HEART CONDITION:

YES NO OTHER:

Is participant subject to: (If "yes" please explain)

YES NO HEADACHES:

YES NO SEIZURES:

YES NO MOTION SICKNESS:

YES NO FAINTING:

YES NO SLEEP WALKING:

YES NO UPSET STOMACH:

YES NO OTHER:

Does participant have reaction to (If "yes" please explain)

YES NO BEE STING:

YES NO PENICILLIN:

YES NO OTHER DRUGS:

YES NO CERTAIN FOODS:

YES NO POISON IVY, OAK, SUMAC:

YES NO OTHER: _____

YES NO Has the volunteer had any serious illness/surgery within the past 3 years:

YES NO Does the participant have any condition that would prevent him/her from participating in any Servant Event activities? Please list:

YES NO Are any drugs ineffective in treatment:

YES NO Is the participant diabetic:

YES NO Does he/she have any sight or hearing impairment:

YES NO Does the participant wear contact lenses? or hearing aids?

Date of last tetanus shot:

A CURRENT TETANUS SHOT IS REQUIRED

Please indicate **ANYTHING** else that leaders should know to help avoid or aid participant with any situations that might arise:

Person we can contact in case you have an emergency:

Name: _____ Phone: _____

Alternate Name: _____ Phone: _____