AMG MISSION ADVENTURES

Health Information Form

Name of team member ______________________________ Age ________

Address ____

Home Phone __________ Work Phone __________ Cell (optional) __________

Name of your Health Insurance Company____________________________________
Policy Number__________________ Office phone number: ________________________
Address of company ____

AMG International requires that all missionaries serving with the organization have adequate medical insurance coverage. Some family health insurance policies will cover short-term overseas travel. Some do not. You must verify with your insurance carrier that your current policy will cover you while you are on the mission for which you are applying.

I have checked with my insurance company or agent and confirmed that my primary medical care coverage will be in effect while I am outside of the United States on this trip. ____Yes ____No

Primary Doctor ____
City ____________ State _____ Phone ____________ Fax ___________
Height _______ Weight _______ Blood Type _______ Eyeglass prescription __________

Is a doctor currently treating you?	Yes	No
Do you have any condition requiring special medical consideration?	Yes	No
Do you or have you had any repertory or heart problems?	Yes	No
Psychological or emotional disorders of limitations	Yes	No
Have you sustained any injury that may limit physical activity?	Yes	No
Are you on a special diet that has been prescribed by a doctor?	Yes	No
Have you had major surgery in the past 3 years?	Yes	No

If Yes for any of the above, please explain (Attach a separate sheet of paper if necessary):

____

____

List any known allergies: medicine (penicillin, aspirin, iodine, acetaminophen, sulfa, other drugs); foods (dairy, wheat, other foods); contact with substances (plants, soaps, other substances); animals, insect bites/stings.

Allergy	Reaction	Medication/Treatment

Has your reaction ever required emergency room care? ____________________

Please list any prescription medications you are bringing (please attach separate sheet of paper if necessary):

Name of drug/ Dosage:	Frequency:	Reason for use:

Do you use any substances that would be hazardous to your health and/or the health of others
Tobacco_____ Alcoholic Beverages_____ Harmful Drugs_____

EMERGENCY CONTACT FORM

For: ______________________________

FIRST CONTACT

Name____

Relationship____

Address____

City______________ State__________ Zip_______________

Home# ____________Work#____________Cell#_______________

Work Hours______________Email_________________________

ALTERNATE CONTACT

Name____

Relationship____

Address____

City______________ State__________ Zip_______________

Home# ____________Work#____________Cell#_______________

Work Hours______________Email_________________________

ALTERNATE CONTACT (optional)

Name____

Relationship____

Address____

City______________ State__________ Zip_______________

Home# ____________Work#____________Cell#_______________

Work Hours______________Email_________________________