



The East Biloxi Coordination, Relief & Redevelopment Agency

# COORDINATION CENTER

## Medical Information Form

*Each volunteer is required to fill out this form prior to being placed on a job site.*

Name: \_\_\_\_\_ Dates of Mission Trip: \_\_\_\_\_

1. Blood Type: \_\_\_\_\_
2. Prescriptions used: \_\_\_\_\_
3. List any know allergies: \_\_\_\_\_
4. Emergency Contact Person: \_\_\_\_\_
5. Contact Number for Emergency Contact: \_\_\_\_\_
6. Health Insurance Company: \_\_\_\_\_
7. Policy Number: \_\_\_\_\_
8. Any physical limitations/concerns or medical conditions we need to be aware of:  
\_\_\_\_\_

I, \_\_\_\_\_ (volunteer,) authorize \_\_\_\_\_ (team leader) to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment and/or hospital care rendered under the general supervision and the advice of any physician or surgeon licensed to practice medicine by the state in which they practice during the duration of the trip identified above and further authorize the release of medical records for the following purpose:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ **I do not consent to the use or disclosure of this information.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Print Parent or Guardian

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Print