Medical Information Form – SP Teams

Participant Information

Name ____ Date of Birth____________________
(As shown on passport) (Day/Month/Year)

Address ____

City ____________________ Province____________________ Postal Code ______________

Home Phone Number ____________________Business Phone Number ____________________

Doctor's Name________________________ Phone Number ________________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name ____

Home Phone Number ____________________ Business Phone Number ____________________

Relationship ____

Medical Information (This information will be shared with the medical person on your team)

Have you ever had or do have any of the following:

	YES	NO
Recurrent Headaches	o	o
Epilepsy	o	o
Fainting Spells	o	o
Asthma	o	o
High Blood Pressure	o	o
Low Blood Pressure	o	o
Tumor/Cancer	o	o
Diabetes	o	o

	YES	NO
Heart Condition	o	o
Anemia	o	o
Rheumatism/Arthritis	o	o
Do you smoke	o	o
Allergy: Bee Stings*	o	o
Other Allergies	o	o

*If you are allergic to bee stings you must bring your own reaction kit

Please specify Allergies
____
____

Do you have ANY other medical conditions the medical person on the trip should be aware of? YES NO

If YES, please explain. ____

Do you have any health condition that might hinder your service or put yourself or others at risk of injury? YES NO

If YES, please explain. ____

Have you had a change in medication or been hospitalized in the last three months as a result of a medical condition (including those checked above)? YES NO

Are you taking any medication at this time? YES NO

If YES, please specify. ____

Are you bringing an adequate supply? YES NO

List any phobias that you may have (heights, small spaces etc.) ________________________________

Provincial Health Care/Insurance # ________________________ Insurance Company ____________________

Phone Number of Insurance Company ____________________ Contact Name ________________________

My policy requires that my insurance company be contacted before any treatment is given. YES NO

I certify that the above information is accurate. I understand that certain medical conditions may preclude acceptance. All required immunizations must be completed at my expense before departure. I agree to accept RBC 'Standard' travel insurance as provided by Samaritan's Purse.

______________________________ ______________________________
Participant Signature Date