North Street Mission

Trinity United Church of Christ 150 E. North St. Wooster, Ohio 44691

Individual Medical Form

Name:			**Birthdate:**
Address:	**City:**	**State:**	**Zip:**

Emergency Contact:		Relationship:
Day Phone: - -	Evening Phone: - -	Cell Phone: - -

Pertinent Health History:

Medical conditions: such as asthma, diabetes etc. and information needed in the event you are unable to answer questions.

Current Medications:

Date of last tetanus shot? **(Strongly recommended that you have had one in the last ten years.)**

Have you ever had a *systemic* allergic reaction to bee stings, food, medicine etc.? Yes No
If yes, what was the precipitating substance and what was the treatment?

We work in the greater Wooster area. Emergency treatment will be provided through available Doctors, Clinics and Hospitals in Wooster. Please remember that caution, careful planning and prevention on your part will greatly reduce theneed for emergency medical treatment. Bring your medications, EpiPen, inhalers or other needed treatments with you.

VERY IMPORTANT INFORMATION – PLEASE READ AND ACT –

Please submit a copy of your medical insurance cards. We suggest that you also give a copyto remain with your group leader during the entire trip.

Health Insurance Information:

Insurance Provider:	Member Number:
Doctor's Name:	Doctors Phone:- -

I hereby authorize the leaders of the group I am participating with or any representative, agent or staff or Trinity United Church of Christ, Wooster Ohio to consent to medical or dental treatment on my behalf including but not limited to any X-ray examination, anesthetic, medical/dental or surgical diagnosis or treatment, and hospital care to be performed by a licensed physician, surgeon, medical clinic, orhospital in Wooster or the surrounding area.

I also hereby authorize the leader(s) of the group that I am participating with or any representative, agent or staff ofTrinityUnited Church of Christ, Wooster, to have access to my medical records, and to disclose the contents to others as they deem necessary.

I hereby release and forever discharge and hold harmless Trinity UCC Wooster and its successors and assigns from any and allliability, claims, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise onaccount of any first aid, medical/dental treatment, or service rendered, or with the decision by any representative or agent ofTrinityUCC Wooster, to exercise the power to consent to medical or dental treatment and disclosure of information.

I understand that,as the volunteer or parent/legal guardian, I will be responsible for the cost of any service or treatment.

Signature of volunteer

If the volunteer is a minor this authorization and consent must be signed by the minor's parent or legal guardian.

Date **Signature of parent/legal guardian**

Complete this form. Print, sign and bring with you to give to Trinity staff upon arrival.

Form Revised 2/20/2014