



International Medical Release Form

This form should be kept by the group leader and not turned in to Servant Life. Place this in the Paperwork Binder provided by Servant Life to take with you while you are traveling.

Church Name: _____ City/State: _____

PERSONAL

Name: _____

Birthdate: ____ / ____ / ____ Age: _____ Gender (M/F): _____

Address: _____

City: _____ State: _____ Zip: _____

In case of emergency contact:

1. Name: _____ Relationship: _____ Phone: () _____

2. Name: _____ Relationship: _____ Phone: () _____

HEALTH INSURANCE INFORMATION

Medical Insurance Co.: _____ Group#: _____

Policy#: _____ Company's Phone: () _____

Company's address: _____

City: _____ State: _____ Zip: _____

Family Physician's Name: _____ Phone: () _____

IMMUNIZATIONS

The following list contains common travel immunizations. This is not a comprehensive list of required immunizations for your mission trip. It is solely the traveler's responsibility to obtain information on required/recommended travel immunizations and travel precautions for the area you are visiting. Please check with your physician and/or www.cdc.gov to ensure your immunizations are current.

Have you received and/or plan to receive the following immunizations? (We do not need to see immunization records. All we need is the following section to be completed.)

<u>Yes</u>	<u>No</u>	<u>Type</u>	<u>Year/Allergies</u>
___	___	Mumps/Measles/Rubella	_____
___	___	Diphtheria/Pertussis/Tetanus	_____
___	___	Polio	_____
___	___	Tetanus	_____
___	___	Hep. A	_____
___	___	Hep. B	_____
___	___	Typhoid	_____

- Rabies _____
- Yellow Fever _____
- Meningococcus _____
- Influenza _____

*Malaria pills are encouraged for some locations, such as South Africa and Ecuador.

MEDICAL HISTORY

Have you ever been treated by a doctor for any of the following:

Yes No

- Asthma or chronic wheezing
- Emphysema or other lung and/or respiratory problems
- Chronic persistent cough or shortness of breath
- Tuberculosis
- Any skin disorder or disease other than acne
- Chronic/recurrent ear or eye problems
- Impairment of hearing or vision: Meniere's Disease, cataracts, or glaucoma
- Persistent, recurring indigestion, stomach, or duodenal ulcers
- Gall bladder stones or colic issues
- Jaundice, cirrhosis, or other liver problems
- Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding
- Any test results indicating exposure to the AIDS virus
- Albumin, blood, or pus in the urine, painful or frequent urination, or kidney problems
- Diabetes or hypoglycemia (low blood sugar)
- Serious bodily injury
- Mental health counseling or psychiatric treatment
- Rheumatism, gout, arthritis, or other forms of swollen, painful joints
- Chronic back pain, back injury or surgery, sciatica, scoliosis, or other bone or joint disorder
- Cysts, tumors, or growths of any kind, hernia, or rupture
- Cancer
- Fainting spells, dizziness, convulsions, epilepsy, or seizure disorder
- High blood pressure, heart murmurs, or other cardiac problems
- Veinous or circulatory trouble
- Severe migraine headaches
- Goiter, thyroid ailment, high or low metabolism
- Anemia or other blood disorder
- Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders, or venereal disease
- Parkinson's Disease
- Severe knee injury or problems
- Severe allergic reactions to either food, medicines, bee stings, or any other insect bite or sting
- Any other diseases, deformity, or disability not listed above

*If you answered "yes" to any of the above questions, please explain on a separate sheet of paper and completely fill out the **Doctor's Release Form**.

• Are you currently taking any prescribed/non-prescription medication on a regular basis? Yes No
 If yes, please specify the medication and the dosage. _____

• Have you ever received treatment/counseling for alcohol/chemical abuse? Yes No
 If yes, please specify when and where. _____

• Are you presently under a physician's care for any illness? ___ Yes ___ No
If yes, please explain. _____

• What was the date and who was the attending physician of your last physical exam? _____

List all surgical operations or hospitalizations you have undergone.

1. Operation, illness, reason, and date: _____

Name and address of hospital: _____

Name of physician: _____

Remaining effects: _____

2. Operation, illness, reason, and date: _____

Name and address of hospital: _____

Name of physician: _____

Remaining effects: _____

If you have been hospitalized more than two times, please give an explanation.

Please provide any details pertaining to your health not covered by the above questions: _____

FAMILY MEDICAL HISTORY

Do your grandparents, parents, or siblings have:

Diabetes ___ Yes ___ No

Hypertension ___ Yes ___ No

Heart Disease ___ Yes ___ No

Depression ___ Yes ___ No

Mental Illness ___ Yes ___ No

If yes, who? _____

ALLERGIES AND DIETARY RESTRICTIONS

List any allergies and your reaction.

ALLERGY:

REACTION:
