Felician Volunteers in Mission
Medical Information Form

Please complete the information below and return it to Felician Sisters of North America: Volunteers in Mission, 871 Mercer Road, Beaver Falls, PA 15010. It is important that this form be completed thoroughly and carefully. Upon completion, we request that it be signed by you. Please note that this information is kept confidential. If you have any questions, please contact Caroline Stanfill at cstanfill@feliciansisters.org or (724) 650-7936.

Location of Trip: ______________________________ **Date(s) of Trip:** ______________________

General Information

First Name: ______________________ MI: ___ Last Name: ______________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Telephone: ( ) ______________________ Email Address: ______________________

Emergency Contact Information

Name: ______________________ Relationship: ______________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Telephone: ( ) ______________________

Insurance Information

I understand that I am responsible for providing my own coverage for health, accident, medical, and hospital insurance during the entire period I will be a participant in this mission trip should I be accepted. I certify that I have received verification from my insurance carrier that my policy will cover me while I am a participant in this program.

Please Initial: ________

Insurance Company: ______________________________ Phone: ( ) ______________

Name of Policy Holder: ______________________________ Relationship: ______________

Group Number: ______________________ Member ID Number: ______________________

Medical Information

Physician's Name: ____ Phone: (______) ____________________

Please check yes or no for each of the following:

QUESTIONS	YES	NO	DETAILS (If yes)
Do you have any Allergies?			
Do you have any Dietary Restrictions?			
Do you have any Physical Disabilities?			
Do you have any Mental Illness?			
Are you on any medications?			
Do you have any other medical conditions that we should know about?			

To Be Completed by a Physician

After a complete physical examination, in my medical opinion the above participant is medically (please check one):

____ able to participate fully in all activities

____ able to participate in activities with limitations. Please explain: ____

____unable to participate in the activities of a mission trip

The above participant has received all necessary immunizations for travel to the above area during the dates specified.

Signature of Health Care Provider: ____ Date: ______________

Address: ____ Phone: (______) ____________________

Applicant's Signature

I confirm that the medical information herein is true to the best of my knowledge.

Signature of Participant: ____ Date: ______________