North Coast Calvary Chapel
Confidential Information for use in
Medical Emergencies

Full Name: ____

Blood Type: ____

Name of your Physician: ____

Address: ______________________________ City: ____________ State: ____ Zip: ______

Office Phone: ( ) Home: ( )

Please list all the drugs/medications you are presently taking indicating the generic name, exact strengths, and dosage.

List medical problems for which you have received medical care in the past 12 months:

List any history of major illness or surgery:

Date of most recent tetanus immunization
List any known allergies (including food allergies) or chronic life-threatening conditions:

Please list any medical conditions helpful for a physician to know should you require emergency medical attention during the trip:

Describe your present physical fitness (e.g., walking, manual labor, heavy lifting, carrying luggage)

Emergency Authorization
I give any licensed, practicing physician or hospital full authority to provide emergency medical treatment for me in the event such treatment is needed or necessary and I am not able to make such a decision. I also hereby give my permission for appropriate care to be administered for me in the event of any medical emergency affecting me.

In Case of Emergency Contact:

Name: ____

Relationship to Applicant____

Address: ____

E-mail Address: ____

Address: ______________________________ City:____________ State:____ Zip: ________

Office Phone: ( ) Home: ( ) Cell Phone: ( )

Signature: ____ Date: _________________