

PERSONAL AND MEDICAL INFORMATION FORM

Name _____ E-Mail _____

Address _____

Home Phone _____ Work _____ Cell _____

Occupation _____ Date of Birth _____

Marital Status _____ Spouse's Name _____

Church _____

Address _____

Phone _____

Emergency Contact

Name _____ Relationship _____

Address _____

Home Phone _____ Work _____ Cell _____

Consent

I hereby give permission for my son / daughter / self (if over 18 years of age) to receive emergency medical attention from a physician in the event of illness or injury.

Signed _____ Date _____

Secondary Insurance Information

Carmel Baptist Church will secure secondary accident and injury insurance for each volunteer during the mission trip. The following information is needed to secure this insurance:

Your Full Name _____

Your Birth Date _____

Beneficiary Full Name _____

Relationship to Beneficiary _____

Beneficiary Birth Date _____