



North Carolina Baptist Disaster Relief

PO Box 1107

Cary, NC 27512 - 1107

(800) 395-5102 Fax (919) 460-6329



NC Baptists on Mission - General Medical Information

Name: (Last) (First) (Middle) Birthday: Age: Sex: M F Marital Status: Weight: Height Address: City: State: Zip: Home Phone: Mobile: Email Address: Emergency Contact Person: Emergency Contact Phone: Church: Association:

MEDICAL STATEMENT (All information requested below must be filled out before participant can take part in the disaster relief program.)

- a. General Health (circle): GOOD FAIR POOR
b. Limitations:
c. Do you have any of the following? If yes, please explain type and severity.

Table with 3 columns: Allergy Type (Medication, Food, Other, Asthma, Diabetes), No, Yes. Includes specific questions like 'Yes (Epinephrine or Hospitalization Required?)' and 'Yes (Insulin Required?)'.

- d. Do you have history of (circle): Heart disease, Hypertension, Appendectomy, Epilepsy, Sleep Apnea
e. Tetanus shot updated? (year)
f. Please list any medications in the table below.

Table with 3 columns: Medication, Reason, Dosage (mg per day). Contains 4 rows for listing medications.

- g. Medical treatment received in the past year:
h. Have you been exposed to any contagious disease in the past six months? If yes, what?

Physician's Name: Address: Office Phone: City: State: Zip:

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

Signature: Date:

INSURANCE

Name of insured: Policy number: Name of insurance company: Address of insured: Address of insurance company:

You must bring this completed form and turn in at registration.