

**Back2Back
EMERGENCY INFORMATION**

Group Name: _____ **Trip Date:** _____

Name: _____ M F Emergency Contact: _____

Home Address: _____ Relationship: _____

City/State: _____ Phone: (____) _____

Zip Code: _____ Physicians Name: _____

Home Phone: (____) _____ Physicians Phone: (____) _____

Office phone: (____) _____ Date of Birth of Trip Participant: __/__/____

Email: _____

HEALTH INSURANCE: Each participant is responsible for medical expenses. Sickness and accident insurance is required, which Back2Back will purchase.

Insurance Co.: _____ Policy #: _____

Street Address: _____ City/State/Zip: _____

MEDICAL INFORMATION:

A. Allergies (including medicines, foods, bites, stings): List below (use back of page if necessary). **O NONE**

Allergy	Reactions	Medication Required

B. Medication: List all current medications below (use back of page of necessary). **O NONE**

Medication	Condition	Dosage (size/frequency)	Current Side Effects

HEALTH PROFILE: Check and describe below

- | | |
|--|---|
| <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><input type="checkbox"/> 1. Pregnant</p> <p><input type="checkbox"/> 2. Medical Equipment</p> <p><input type="checkbox"/> 3. Seizure within the past 1 year</p> <p><input type="checkbox"/> 4. Hospitalization/Emergency Room visit within the past year</p> <p><input type="checkbox"/> 5. High blood pressure, even if being treated with medication</p> <p><input type="checkbox"/> 6. Neck/back/shoulder/knee/ankle problem</p> | <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><input type="checkbox"/> 7. History of heart attack/by-pass/angioplasty/angina</p> <p><input type="checkbox"/> 8. Other cardiac conditions (heart murmur/irregular heartbeat (specify below)</p> <p><input type="checkbox"/> 9. Diabetic requiring medication</p> <p><input type="checkbox"/> 10. Known abnormally high cholesterol level or on a special diet or medication</p> <p><input type="checkbox"/> 11. Please list or describe anything else of which Back2Back should be aware regarding your medical conditions (physical, mental, etc)</p> |
|--|---|

Issue #	Detailed description including symptoms/any restrictions (use back of page if necessary)

AUTHORIZATION:

NOTARIZE THIS PAGE

FOR MINORS/ADULTS:

I/we individually and/or as parents and natural guardians of my/our minor child do hereby authorize, permit and consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor/adult under the general or special supervision and on the advice of any physician or dentist duly licensed on the medical staff of a licensed hospital, clinic or emergency care center whether such diagnosis or treatment is rendered at the office of said physician or at said hospital, clinic or emergency care center.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child or for me pursuant to this authorization.

Should it be necessary for me/my child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

SIGNATURE REQUIRED:

Consent is hereby given for the applicant to attend a Back2Back Mission Trip and permission is given for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary.

All information will remain confidential. You should know that over the years, many participants with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants.

Name of participant: _____

Name of parent/guardian: _____

Signature of participant: _____

Signature of Parent/Guardian: _____

Date: _____

Notary: _____

My Commission Expires: _____

Date: _____

SEAL