

SOUTHERN BAPTIST DISASTER RELIEF - REGION 4A

Arkansas, Texas-TBM, Texas-SBTC, Missouri, Louisiana, Oklahoma

MEDICAL RELEASE FORM

Name: Last		First		Middle	
Address:		City		State	Zip
Phone: (H)		(C)		(W)	
Date of Birth		Spouse Name			

Emergency Contact	Spouse Cell		Work	
1.)		Relationship		Phone
2.)		Relationship		Phone

Church:		City		Phone
Association				
Pastor:		Phone (H)		Cell

Physician:	Phone
Medical Insurance Co.	Policy #

MEDICAL HISTORY		Year Date of Last Tetanus Shot	
<input type="checkbox"/> Allergy (explain reaction)	<input type="checkbox"/> Broken Bone (explain)	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Food/Meds/Plant/Insect	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mononucleosis	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Past Surgery (explain)	
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Blood Pressure High/Low	<input type="checkbox"/> Heart Disease (explain)	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Blood Disorder (explain)	<input type="checkbox"/> Hepatitis A/B/C	<input type="checkbox"/> Other (explain)	

Please explain the above noted health problems and any additional special medical conditions of which the Unit Leader (Blue Cap) should be aware: (may use back if needed)

MEDICATION: List medications taken on a regular basis with dosage and time to be taken		
		Use back of form if more room is needed

THE FOLLOWING STATEMENT WILL BE SIGNED WHEN THE UNIT IS ACTIVATED
The above information is accurate to the best of my knowledge. I understand this form will be kept by the Unit Leader (Blue Cap) for use if needed. I give permission to release information to medical personnel if necessary. Should I be unconscious, I give permission to a Southern Baptist Disaster Relief representative to act as spokesman in granting permission for emergency treatment (including anesthesia) if necessary.

Signature	Date
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