PASSION Ministry's Medical Form

Participant Name:______________________________________ Age:____

Address:____ Phone:_____________

In Case of Emergency, Please Contact:

Name:____ Relationship:_______________

Work Phone:_______________
Home Phone:________________
Cell Phone:________________

Medical Information:

Do you have asthma?___Yes ___No Diabetes? ___Yes ___No Epilepsy? ___Yes ___No

Do you have any allergies? ___Yes ___No
If so, please explain:

Are you taking any medication? ___Yes ___No
If so, please explain:

Do you have any dietary restrictions?___Yes ___No
If so, please explain:

Do you have any disabilities? ___Yes ___No
If so, please explain:

Do you have any heart conditions?___Yes ___No
If so, please explain:

Do you have any phobias or fears?___Yes ___No
If so, please explain:

Have you had any past surgeries or injuries?___Yes ___No
If so, please explain:

Do you have any other medical conditions?___Yes ___No
If so, please explain:

Medical Insurance Coverage:

Company:______________________________________ Policy#:__________________

Address:____ Phone#:_____________

I authorize by signature that the information provided is truthful and correct. Furthermore I give my consent to the weekend leaders or other medical personnel to treat me in an emergency situation.

Signature:____ Date:_______

Print Name:____

If participant is a minor:
Parents/guardian Signature:____Date:_______

Print Names:____