

NORTH CAROLINA BAPTIST DISASTER RELIEF GENERAL MEDICAL INFORMATION

(To be filled out by applicant)



		<u> </u>	Birthday:	
Age: Sex	_			
(last) Address:	(first)	(middle)		
City:		State	Zip:	
rionie pnone: ()	Cell_phone: ()	Email:	_
Marital Status:	Weight:		Height:	
Emergency Contact Person:_	<u> </u>		Telephone: ()	
MEDICAL STATEMEN	т			
(All information requested below		participant can taka nam in	the dispets will of	
Medical History:	··· mase se mica out setote p	articipant can take part m	the disaster reflet program.)	
a. General Health:				
b. Limitations:				
	trick knee weak a	nkles had back	other	_
d. Are you subject to:	diahetes enilens	V heart disease	hypertension other	
e. Appendix removed?	f. Tetai	nus shot updated?	other	_
g. Medicines taken:_	Reason	t		
	Reason	•		
	Keason	·		
II. Allergies(food, drugs, other);				
medications asca to tical affer	igies			
. Medicai freatment received in	the past year:			
 Have you had or been expose 	d to any contagious disease i	n the past six months?	If so, what?	
. Have you had or been expose Physician's Name:	d to any contagious disease i	n the past six months? Office	Phone: ()	
. Have you had or been expose Physician's Name:	d to any contagious disease i	n the past six months? Office	If so, what? e Phone: () 	
Physician's Name:	d to any contagious disease i	n the past six months? Office	Phone: ()	
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Physician's Name: Address CONSENT I hereby give permission for medical attention from a position of medical attention f	or my son / daughter / ohysician in the event of:	n the past six months? Office City: self (if over 18 years of illness or injury. Date: he is in fit health for	e Phone: (

You must bring this with you filled out. Please leave it with the contact person when you check in. Be sure to also sign in the volunteer register when you check in. Thanks.