

Wayside Chapel Medical Information

Name _____ Age (if under 18) _____ Male _____ Female _____
Address _____ Phone # (_____) _____
City _____ State _____ Zip _____
Insurance Co. _____ Policy # _____
Policy Holder's Name _____ Social Security # _____
Address _____ Phone # (_____) _____
Policy Holder's Employer _____ Phone # (_____) _____
Guarantor Name (if different from Policy Holder) _____
Address _____ Phone # (_____) _____
City _____ State _____ Zip _____
Date of Last Tetanus Shot _____

List any major illnesses within the past year _____

List any medications you take regularly _____

NOTE: Be sure to take an ample supply for your length of service and get a written prescription from your doctor to give to your Group Leader just in case!

List those things to which you are allergic _____

List any physical disabilities or current health issues _____

In case of emergency, please contact:

Name _____ Home Phone # _____
Address _____
City _____ State _____ Zip _____
Relationship _____ Work Phone # _____

For Your Doctor

I have examined _____ and find him/her to be in good general health and physically able to take part in a Wayside Chapel trip. Conditions that Wayside Chapel should be aware of are:

Doctor's Signature

Date

Parent's/Guardian Signature

Date