West Ohio Conference
Volunteers in Mission: Medical Information

Missioner's Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

☐ Home ☐ Cell ☐ Work

UMVIM
UNITED METHODIST VOLUNTEERS IN MISSION

When completed, please return to Team Leader

A copy of this form will be left with the local church or conference office in the event of an emergency.

Mission Project

UMVIM Location & Task: _____ Dates _____

Have you been on previous projects/mission journeys: ☐ Yes ☐ No Home Church _____

Personal Medical Information

Personal Medical History:

☐ Diabetes ☐ Seizures ☐ Hypertension ☐ Cardiac disease ☐ Back pain ☐ Arthritis

☐ Mental Illness ☐ Other _____ Blood type: _____

Physical Limitations: _____

Allergies: _____

Medications: _____

Immunizations: Last Tetanus/Diphtheria *(recommended every 10 years)* ____/____/____
(CDC can provide up-to-date country specific information on immunizations for travelers at www.cdc.gov/travel)

Medical Insurance Provider _____ Phone: _____

Policy # _____ Group # _____

Physician: _____ Phone: _____

Medical Consent

I *(UMVIM Participant)* _____

authorize *(other adult participant)* _____, if I am unable to do so, to consent to receiving first aid or necessary medical treatment and/or hospital care rendered under the supervision and advice of any physician licensed to practice medicine by the state in which he/she practices during the duration of the identified mission journey.

*Emergency Contacts**

Emergency Contact: _____ Relationship: _____

Address: _____

Phone(s): _____

Secondary Contact: _____ Relationship: _____

Address: _____

Phone(s): _____

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to be completed by Missioner's physician

I, *(Missioner's Name)* _____, plan to participate in a United Methodist Volunteers In Mission journey from _____/_____/_____ to _____/_____/_____ in _____
Dates of Mission Journey Location of Mission Journey

I may be doing manual labor in a climate that is:____hot and humid; ____cold and damp; ____ other (_____) Health care facilities may be inadequate or nonexistent.

Please consult the CDC for updated age-based vaccinations and schedules at:

https://www.cdc.gov/vaccines/schedules/index.html

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Please sign below if you agree that my general health is adequate for this endeavor. If you are not familiar enough with my physical health, I agree to have a physical examination and laboratory tests if indicated as part of my application process.

For Use by Medical Professional

Signed _____ Credentials _____ Date _____
Physical exam performed: _____Yes _____ No

Print Name _____ Phone:_____
Address _____
City / State / Zip _____