



Missionary Cenacle Volunteers
Trinity Mission Center
Emergency Medical Information

Applicant's Name: _____

In case of emergency please notify:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home (_____) _____ Office (_____) _____

Relationship: _____

1. Your blood type, if known _____
2. Are you currently taking any medication (even children's aspirin)? Yes No

If yes, what? _____

What is this medication taken for? _____

How often do you have to take the medication? _____

3. Do you have any allergies including medications? Yes No

If yes, to what? _____

4. Do you require a special diet? Yes No

If yes, please explain _____

5. Are you currently under the care of a physician? Yes No

If yes, for what? _____

6. Do you have medical insurance? Yes No

If yes, please fill in the following:

Name of Insurance carrier _____

Address _____

City _____ State _____ Zip _____

Policy # _____

*If you do not currently have medical coverage, please contact us for information on temporary mission insurance.

(Over Please)

Address of your Doctor(s):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____

Do you have any lifesaving (swimming) training? Yes No If yes, Specify:

_____ Beginner _____ Intermediate _____ Advanced

Are you certified by the Red Cross in First Aid? Yes No If yes, specify:

_____ Beginner _____ Intermediate _____ Advanced

Are you certified in Cardio Pulmonary Resuscitation (CPR)? Yes No

If you are interested in certification in lifesaving (swimming), First-Aid, or CPR you can call your local Red Cross for the time and place of classes in your area.

I hereby affirm that the above information is accurate to the best of my knowledge.

Name (please print)

Date
