



Please send to:
Belize Mission & Retreat
c/o Rae Reed
22413 Marion Lee Rd.
Gentry, AR 72734

CONFIDENTIAL MEDICAL HISTORY

Please provide the following information. All areas need to be completed.

Personal Information

Name of applicant: _____

Emergency Contact

| | |
|---|---|
| <p>First</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Day phone: _____</p> <p>Home/Eve phone: _____</p> <p>Additional information: _____</p> | <p>Second</p> <p>Name: _____</p> <p>Relationship: _____</p> <p>Day phone: _____</p> <p>Home/Eve phone: _____</p> |
|---|---|

Medical Coverage

Physician's name: _____ Phone number: _____

Are you covered by medical insurance? Yes No

Name of insurance company: _____

Policy Number: _____ Group Number: _____

Address of insurance company: _____

**** Please staple a copy of your medical insurance cards (front and back) to this form**

Pre-existing Conditions/Illnesses

| | YES | NO | | YES | NO |
|-----------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory/emphysema | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/infectious disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Colitis | <input type="checkbox"/> | <input type="checkbox"/> | Migraine headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy (seizures) | <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disorder | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric disorder | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism/drug use | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |

Date of last tetanus shot: _____ Date of last hepatitis shot: "A" _____ "B" _____

Other pre-existing conditions or illnesses or explanation of any "YES" answers above: _____

Injuries

| | YES | NO | | YES | NO |
|--------------|--------------------------------------|--------------------------|------------------------|--------------------------------------|--------------------------|
| Head injury | <input type="checkbox"/> Date: _____ | <input type="checkbox"/> | Recurrent ankle injury | <input type="checkbox"/> Date: _____ | <input type="checkbox"/> |
| Back injury | <input type="checkbox"/> Date: _____ | <input type="checkbox"/> | Recurrent knee injury | <input type="checkbox"/> Date: _____ | <input type="checkbox"/> |
| Broken bones | <input type="checkbox"/> Date: _____ | <input type="checkbox"/> | Other: _____ | <input type="checkbox"/> Date: _____ | <input type="checkbox"/> |

List broken bones, if any: _____

Medications

List all medications your are currently taking:

| Name | Dosage | Frequency |
|-------|--------|-----------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please explain the condition(s) you are treating with medication: _____

Allergic reactions

Do you have allergies, including reactions to food, penicillin, antibiotics or other medications? YES NO

If yes, please explain: _____

Do you carry a personal epi-kit in case of an allergic emergency? YES NO

Dietary Needs

Do you have any special dietary needs? YES NO

Are you a vegetarian? YES NO

If yes, please specify or describe the need (i.e., vegan, no dairy, no red meat, etc.): _____

Special Needs

Do you have any physical, mental or emotional conditions which would limit your full participation or that we should be made aware of? YES NO

If yes, please describe: _____

Signature _____ Date _____