# Sowers of Seed Missions

## EMERGENCY MEDICAL INFORMATION

*(To be filled out and submitted by all participants)*

Participant's Name _____
Last First M.I. Date of Birth

Address _____

Home Phone _____ Email _____

Emergency Contact Person _____
Name Relationship Phone

Health Insurance Company _____

ID/Policy # _____ Group # _____

Employer (adult) _____

Parents Name (youth) _____

Are you a member of an HMO? Y N Primary Care Physician _____

Are you taking any medication at present? Y N Are you allergic to any medications? Y N

List: _____

Non-prescription medications you do not want to receive _____

Have you had a tetanus shot within the last five (5) years? Y N

Are you allergic to any of the following: ____ Bee stings ____ Food allergies ____ Skin allergies

Do you have a history of any of the following: _____ Diabetes _____ Seizures ____ Asthma

Have you ever had hepatitis? Y N Do you have current medical problems or restrictions? Y N

If so, indicate _____

I give permission for the adult team supervisor to transport and request medical attention for my child.

_____
Signature of participant Parent Signature if participant is under 18

NOTE: The above stated insurance coverage will be applied in all situations requiring medical attention

Please print this form on one page and return to SNL at time of registration