**Crest-English_colourShort-Term Overseas Missions**

**Health History Form**

The Salvation Army, Territorial Headquarters, Canada and Bermuda

*World Mission Office*

2 Overlea Blvd., Toronto, Ontario M4H 1P4 Phone: (416) 425 – 2111 Ext. 2305

**APPLICANT NAME:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Medical Information*** | | | |
| Family Doctor |  | Phone # |  |
| Blood Type |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Primary Contact Information*** | | | |
| Name |  | Relationship |  |
| Home Phone |  | Business Phone |  |
| Cell Phone |  | Email Address |  |
| ***Secondary Contact Information*** | | | |
| Name |  | Relationship |  |
| Home Phone |  | Business Phone |  |
| Cell Phone |  | Email Address |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Provincial Health Insurance*** | | | | | | |
| Name on Card | |  | | Card # |  | |
| Expiry Date | |  | | Province |  | |
| ***Secondary Health Insurance*** | | | | | | |
| Company |  | | Plan/Policy # | | |  |
| Expiry Date |  | | Contact # | | |  |
| ***Travel Insurance (Including Trip Cancellation)*** | | | | | | |
| Company |  | | Plan/Policy # | | |  |
| Expiry Date |  | | Contact # | | |  |

List all known medical conditions, physical limitations, and allergies:

**PLEASE ATTACH A COPY OF YOUR PRESCRIPTION** – This will assist for immediate replacement if misplaced during your mission trip.

**Make sure that all prescribed medications are clearly marked on medication containers with your name and dosage information. Also, it is advisable that you carry a copy of the doctor’s prescription for all medications that you plan to carry with you.**

**CONSENT**:

I authorize by signature that the above is truthful and correct. In the event that I am injured or become ill while overseas or en route to or from my overseas mission assignment, I hereby authorize the team leader in charge of the project to secure such medical advice and services as may be deemed necessary for the health and, in circumstances, safety of myself. I agree to accept full financial responsibility for all costs incurred in excess of the benefits allowed by the Provincial health Insurance or the out of country insurance plan which I have purchased,

1. Where my health and well-being is involved

2. Where medical advice has been such that further services are required

3. Where, due to the nature of the emergency, there is insufficient time to contact the

next-of-kin.

SIGNATURE: DATE:

WITNESS: DATE: