



Beautiful Savior Lutheran Church Mexico Mission
Adult Health History Form

(Effective June 17-24, 2023)

Participant's Name: _____ Sex: _____ Birthdate: _____

Home Address: _____
(Street address / Apt. #) (City) (St.) (Zip)

Please list the names of two relatives, friends, or neighbors to be called if you cannot be reached in case of emergency.

Name Phone

1. _____

2. _____

Please list your physician in case additional medical history is needed in the event of an emergency.

(Physician's Name) (Phone)

(Health Insurance Plan Name) (Primary Insured) (Group #) (Member #)

Health History *(Check box for yes)*

Heart Disease Epilepsy/Seizures Asthma Diabetes

Allergies

Hay Fever Insect Stings Which insects: _____

Drug Allergies Which drugs: _____

Food Restrictions: _____

Date of Last Tetanus booster (Every 10 years) _____

Current Medications _____

(You will need to be responsible for your own medications)

Other Health Issues _____

This health history is correct as far as I understand, and I am herein described, as free of potential health problems which might restrict my participation (except as noted). In the event I cannot be reached in an emergency, I hereby give permission to the physician, hospital, clinic selected by the Mission leaders to treat, hospitalize, secure proper anesthesia, injections or surgery.

Signature of Participant _____ Date _____