

**CROSS ROADS MISSION TRIP  
MEDICAL INFORMATION AND AUTHORIZATION FORM**

Name: \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Emergency Contact Name(s): \_\_\_\_\_

Contact Number (s): \_\_\_\_\_

Physician: \_\_\_\_\_ Number \_\_\_\_\_

Dentist: \_\_\_\_\_ Number: \_\_\_\_\_

**INSURANCE INFORMATION**

Carrier or Plan Name: \_\_\_\_\_

Identification # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

**MEDICAL INFORMATION**

List all Allergies (food, insect stings, medicines etc.) \_\_\_\_\_

\_\_\_\_\_

List all Medications student is taking (including all over the counter and non-prescription drugs):

\_\_\_\_\_

List any Restrictions (food, activity, etc.): \_\_\_\_\_

\_\_\_\_\_

Are vaccinations up to date? \_\_\_\_\_ Date of Tetanus Booster: \_\_\_\_\_

Please provide any additional information about the participant's behavior and physical, emotional or mental health about which the counselors should be aware: \_\_\_\_\_

\_\_\_\_\_

**Parent/Guardian Authorization: In the case of a medical emergency, I understand that every effort will be made to contact me. I also understand that the pastor, sponsor(s), chaperone(s), and/or driver(s) will secure proper treatment (doctor, medical, hospitalization, injection, surgery, etc.) for him/her. I expect to assume full responsibility for all illnesses and/or accidents which may occur on the trip.**

Parent/Guardian Signature: \_\_\_\_\_