Medical Information for Adults

Name:_____

Phone Number:_____

Address:_____

Birthdate:_____

Allergies:_____

Medical/Special Issues:_____

Insurance Co:_____

Policy / Group #:_____

Insurance Phone #:_____

Family Physician:_____

Family Physician Phone Number:_____

Emergency Contact:_____

Emergency Contact Phone Number:_____

I hereby appoint the leadership trip members of the 96:3 Project to act in my/our behalf in authorizing unexpected medical care, dental care, and hospitalization for me if I'm not able to give my own consent during the period from:
Month/date/year_____ through
Month/date/year_____.

This document shall be presented to a physician, dentist, or appropriate hospital representative at such times as unexpected medical care, dental care, and/or hospitalization may be required.

Signature_____