Keystone Church

Student Emergency Contact and Medical Information

Please indicate where your student will be volunteering:

Site_____ Dates of Mission Trip _____

PERSONAL INFORMATION

Student's Name: _____

Student's Cell Phone: _____

DOB: _____ / _____/ _____ Age (as of Date of Trip): _____

EMERGENCY CONTACT INFORMATION

Father's / Guardian's Name: _____

Father's/Guardian's Cell Phone: _____ Home Phone: _____

Mother's/Guardian's Name: _____

Mother's/Guardian's Cell Phone: _____ Home Phone: _____

Insurance Company: _____ Group #: _____

Policy #: _____ Card Holder: _____

Relationship to Cardholder: _____

Insurance Company's Address: _____

Insurance Phone: _____

In the event of an accident, the parent(s)/legal guardian(s) of the student will be contacted. Please list one additional contact in case the parent/legal guardian cannot be reached.

Name: _____ Relationship to Student: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

PERSONAL MEDICAL INFORMATION

Physician's Name: _____ Phone: _____

Does the student volunteer have any medical condition, rare blood type, diabetes, and/or take any medication of which Keystone or Keystone's Trip Leader should be aware of?

YES NO

If YES, please explain in detail, including any medications that will be taken during the trip, both prescribed and over-the-counter.

_____

_____

_____

_____

Does the student have any allergies to food, dust, bee stings or other allergens?

YES NO

If YES, please list all known allergies.

_____

_____

List all operations/serious injuries and date within the past 5 years.

_____

_____

It is the responsibility of the student volunteer and his/her parent/legal guardian to ensure that the student volunteer brings an adequate supply of any medication that will be needed, including, without limitation, any EpiPen, asthma inhaler, antibiotics, etc.

Date of last Tetanus Vaccine: _____

_____ _____

(Signature of Parent/Legal Guardian) (Date)

Print Name_____Email_____

Cell Phone_____