



Mountain Chapel Mexico Mission Trip 2026

MEDICAL & EMERGENCY CONTACT FORM

Complete one form per participant • Keep a copy for your records

⚠ Important: This form must be completed for each participant and submitted to the trip coordinator before departure. Medical information will be kept confidential and used only in case of emergency.

PARTICIPANT INFORMATION

FULL NAME *	DATE OF BIRTH
FAMILY LEADER NAME	

PRIMARY EMERGENCY CONTACT

NAME *	RELATIONSHIP *
PHONE NUMBER *	ALTERNATE PHONE
EMAIL ADDRESS	

SECONDARY EMERGENCY CONTACT

NAME	RELATIONSHIP
PHONE NUMBER	

MEDICAL HISTORY

KNOWN MEDICAL CONDITIONS (DIABETES, ASTHMA, HEART CONDITIONS, SEIZURES, ETC.)

MEDICAL HISTORY (CONT.)

CURRENT MEDICATIONS (INCLUDE DOSAGE AND FREQUENCY)

ALLERGIES — FOOD

ALLERGIES — MEDICATION

ALLERGIES — ENVIRONMENTAL (INSECT STINGS, LATEX, ETC.)

INSURANCE INFORMATION

HEALTH INSURANCE PROVIDER	POLICY NUMBER
PRIMARY CARE PHYSICIAN	PHYSICIAN PHONE

MEDICAL AUTHORIZATION

In the event of a medical emergency, I hereby authorize the trip leaders to seek and consent to medical treatment for the participant named above. I understand that every effort will be made to contact me before any medical decisions are made.

SIGNATURE (PARENT/GUARDIAN IF MINOR) *	DATE *
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