NCBM DISASTER RELIEF
GENERAL MEDICAL INFORMATION
(To be filled out by applicant)

Name:____
(last) (first) (middle)
Birthday: ____________________ **Age:** ____________________ **Sex:** **M** **F**
Address:____
City:____________________ **State**__________ **Zip:**__________
Home phone: (______)__________________ **Mobile phone:** (__________)__________
Email:____________________ **Marital Status:** ______ **Weight:**__________ **Height:**______
Emergency Contact Person: ____________________ **Telephone:** ______________
Church:____________________ **Association:**____________________

MEDICAL STATEMENT ***(All information requested below must be filled out before participant can take part in the disaster relief program.)***

a. General Health: **GOOD** **FAIR** **POOR**

b. Limitations: ____

c. Do you have any of the following? If yes, please explain type and severity:

Medication Allergies	NO	YES ____________________
Food Allergies	NO	YES ____________________
Other Allergies	NO	YES ____________________
Asthma	NO	YES **Epinephrine or Hospitalization Required?**
Diabetes	NO	YES **Insulin Required?** ____________

d. Do you have a history of (circle): Heart disease Hypertension Appendectomy Epilepsy Sleep Apnea

e. Tetanus shot updated? __________ (year)

f. Medication List: __________________ Reason: __________ Dosage: __________ Pills Per Day: __________
__________________ Reason: __________ Dosage: __________ Pills Per Day: __________
__________________ Reason: __________ Dosage: __________ Pills Per Day: __________
__________________ Reason: __________ Dosage: __________ Pills Per Day: __________

g. Medical treatment received in the past year:______________________________

h. Have you been exposed to any contagious disease in the past six months? _______ If so, what? __________

Physician's Name: ____________________ **Office Phone**: (______)__________

Address____________________ City:__________ Zip__________

CONSENT

I hereby give permission for my son / daughter / self (if over 18 years of age) to receive emergency medical attention from a physician in the event of illness or injury.

Signed:______________________________ Date:____________________

INSURANCE

Insurance issued in the name of:______________________________

Address of insured:______________________________

Name of insurance company:______________________________

Address of insurance company:______________________________

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Policy number:______________________________

You must bring this completed form and turn in at registration. Rev.3/2/2020