West Ohio Conference
Volunteers in Mission: Medical Information

Missioner's Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

☐ Home ☐ Cell ☐ Work

UMVIM
UNITED METHODIST VOLUNTEERS IN MISSION

When completed, please return to Team Leader

A copy of this form will be left with the local church or conference office in the event of an emergency.

Mission Project

UMVIM Location & Task: _____ Dates _____

Have you been on previous projects/mission journeys: ☐ Yes ☐ No Home Church _____

Personal Medical Information

Personal Medical History:

☐ Diabetes ☐ Seizures ☐ Hypertension ☐ Cardiac disease ☐ Back pain ☐ Arthritis

☐ Mental Illness ☐ Other _____ Blood type: _____

Physical Limitations: _____

Allergies: _____

Medications: _____

Immunizations: Last Tetanus/Diphtheria (recommended every 10 years) ____/____/____
(CDC can provide up-to-date country specific information on immunizations for travelers at www.cdc.gov/travel)

Medical Insurance Provider _____ Phone: _____

Policy # _____ Group # _____

Physician: _____ ***Phone:*** _____

Medical Consent

I (UMVIM Participant) _____

authorize (other adult participant) _____, if I am unable to do so, to consent to receiving first aid or necessary medical treatment and/or hospital care rendered under the supervision and advice of any physician licensed to practice medicine by the state in which he/she practices during the duration of the identified mission journey.

*Emergency Contacts**

Emergency Contact: _____ Relationship: _____

Address: _____

Phone(s): _____

Secondary Contact: _____ Relationship: _____

Address: _____

Phone(s): _____

**Emergency Contacts should be the same as those found on the "VIM Emergency Contact Form"*

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to be completed by Missioner's physician

I, *(Missioner's Name)* _____, plan to participate in a United Methodist Volunteers In Mission journey from _____ to _____ in _____

Dates of Mission Journey *Location of Mission Journey*

I may be doing manual labor in a climate that is:_____hot and humid; _____cold and damp; _____ other (_____) Health care facilities may be inadequate or nonexistent.

The United Methodist Fellowship of Health Care Volunteers suggests the following immunizations and prophylactic medications:

RECOMMENDED IMMUNIZATIONS (ROUTINE)

Vaccine	Schedule
Diphtheria/Tetanus/Pertussis (TDAP)	Every 10 Years
COVID-19	Vaccine + Available Booster(s)
Polio	Single Booster, OPV
MMR	1 Month Before Travel if Non-Immune

For travel outside of the United States of America, please consult the CDC website: *www.cdc.gov/travel* for country specific information on immunizations and prophylactic medications.

Please sign below if you agree that my general health is adequate for this endeavor. If you are not familiar enough with my physical health, I agree to have a physical examination and laboratory tests if indicated as part of my application process.

For Use by Physician:

Signed _____M.D. Date _____

Physical exam performed: _____Yes _____No

Print Name _____ Phone:_____

Address _____

City / State / Zip _____

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