

## MISSION TRAVELERS MEDICAL RECORD (2022)



Traveler's Name:					
DOB:					
Blood Type:		(Confirmed by: Please Initial)			
List any/all ongoing med	lical conditions:				
	otion and over the counter) inclu		es. (Example below)		
Medication Amiodipine	Milligrams 5 mg	Dose 2 X Day			
Amoupile	58	27.009			
*Please use a separate she	eet of paper if necessary				
	ood or medications? Yes_ food		If yes, list		
Emergency Contact Info	rmation:				
Name:		Phone:			
E-mail address:					
Emergency Health Care	Provider:				
• •		Phone:			
Provider's E-mail Addres	ss:				
	: I,				
• •	nformation above to Nina Watkir	is, Mission Director or Ch	arles E. Cato Sr.,		
Executive Director, Four	Corners International Missions.				
	Please Return Form To: Mission	works06@aol.com			

Questions Call: Nina Watkins, Mission Director Cell: 240.882.6881

## **MEDICAL HISTORY**

Please check if you have ever experienced any of the following conditions:

	Coronary Artery Disease	Migraine Headaches
🗆 Anemia	COPD (Emphysema)	Myocardial Infarction
🗆 Angina	Crohn's Disease	Osteoarthritis
Anxiety	Depression	Osteoporosis
Arthritis	Gallbladder Disease	Peptic Ulcer Disease
🗆 Asthma	GERD (Reflux)	Renal Disease
Atrial Fibrillation	Hepatitis C	Seizure Disorder
Benign Prostatic Hypertrophy	Hyperlipidemia	Thyroid Disease
Blood Clots	Hypertension	
Cancer Type:	Irritable Bowel Disease	
Cerebrovascular Accident	Liver Disease	

I do hereby give Four Corners International Mission (FCIM), and any other health care provider that has been approved by the Executive Director or Mission Director authority to request and authorize medical and/or hospital treatment for my benefit in the event of any injury or sickness sustained by me while on any such travel, stay or other activity, including, without limitation, while traveling to and from any foreign county. I agree to pay for all such treatment and to reimburse FCIM for all costs and expenses incurred by them with respect to such treatment.

## AUTHORIZATION: (Mission Travelers Full Name, Please Print)

Signature

Date

## SUGGESTED SHOT REQUIREMENTS (International Travel Only)

DTaP (Diphtheria, Tetanus,	Hepatitis A & B	*Malaria
Pertussis)		
Meningitidis	Typhoid	Yellow Fever

\*Note: Please obtain Malaria prescription from your Primary Care Physician

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