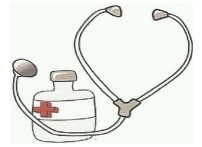




# MISSION TRAVELERS MEDICAL RECORD (2022)



Traveler's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Blood Type: \_\_\_\_\_ (Confirmed by: Please Initial \_\_\_\_\_)

List any/all ongoing medical conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List medication (prescription and over the counter) including milligrams and doses. (Example below)

Medication	Milligrams	Dose
Amiodipine	5 mg	2 X Day

*\*Please use a separate sheet of paper if necessary*

Are you allergic to any food or medications? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list  
name of medication or food \_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Emergency Health Care Provider:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Insurance #: \_\_\_\_\_

Provider's E-mail Address: \_\_\_\_\_

**HIPPA AUTHORIZATION:** I, \_\_\_\_\_ hereby authorize the use or disclosure of my protected health information above to Nina Watkins, Mission Director or Charles E. Cato Sr., Executive Director, Four Corners International Missions.

Please Return Form To: [Missionworks06@aol.com](mailto:Missionworks06@aol.com)

Questions Call: Nina Watkins, Mission Director

Cell: 240.882.6881



**SUGGESTED SHOT REQUIREMENTS (*International Travel Only*)**

DTaP (Diphtheria, Tetanus,  
Pertussis)  
Meningitidis

Hepatitis A & B  
Typhoid

\*Malaria  
Yellow Fever

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

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Cell: 240.882.6881