MISSION OF MIRACLES 2017

Confidential Health Information

Name_____ Date of birth_____

Address_____ Phone Number_____

_____

Person to contact in case of an Emergency_____

Relationship_____ Phone Number_____

List any medical conditions to be disclosed only in case of emergency: _____

_____

_____

Medications: _____

_____

Allergies: _____

_____

The Episcopal Diocese of Central New York and those volunteering as the 2017 Mission of Miracles team cannot be held responsible for any illness or injury that could occur to me while traveling with the team.

Signature_____ Date_____

Witness _____ Date_____