

CAPITOL CITY MEDICAL TEAMS EMERGENCY FORM

(revised 4-26-10)

Please complete the form below before your medical trip. Contact Eric Miller at (503) 378-7343 or at the email below if you have questions. Then return it to:

Capitol City Medical Teams, 4950 Chauncey Court SE, Salem, OR 97302,
or melabea@aol.com

1. LIST YOUR NAME AS IT EXACTLY APPEARS ON YOUR PASSPORT, ADDRESS, AND PHONE NUMBER(S). LIST THE ROLE YOU WILL PERFORM ON THE TRIP.

Name Exactly as on Passport and Address:

Phone #'s:

Role:

2. EMAIL:

3. PASSPORT NUMBER:

EXPIRATION DATE:

4. YOUR EMERGENCY CONTACT NAMES AND PHONE NUMBER(S). LIST TWO CONTACTS IF POSSIBLE.

5. LIST YOUR LIMITATIONS, ALLERIGIES, OR PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING.

Limitations:

Allergies:

Medications:

6. VACCINATION INFORMATION (Include dates of vaccinations as best as possible.)

Tetanus (7 years) _____

Hepatitis A (once) _____

Hepatitis B (once) _____

Polio (once) _____

Yellow Fever (10 years) _____

Typhoid (5 years) _____

based upon the following website:

wwwn.cdc.gov/travel/yellowbookch1-genrecvaccination.aspx#619

Malaria prophylaxis may be required for some trips.

7. MY NAME AND PICTURES CAN BE USED FOR PROMOTIONAL PURPOSES, INCLUDING POSTING ON THE CCMT WEBSITE.

___ YES

___ NO

8. YOUR MEDICAL INSURANCE CARRIER WILL BE BILLED FOR MEDICAL CHARGES IN CASE OF AN ILLNESS OR INJURY DURING A CAMPAIGN. YOUR TEAM LEADER WILL BE GIVEN A COPY OF THIS FORM.

Signature of Applicant

Date of Signature