CAPITOL CITY MEDICAL TEAMS EMERGENCY FORM

(revised 7-31-16)

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, 3275 Crestview Dr. S., 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(S):

3. PASSPORT NUMBER: EXPIRATION DATE:

4. TWO EMERGENCY CONTACT NAMES AND PHONE NUMBER(S).

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/Diphtheria (10 yrs.)	_____	**Hepatitis A (once)**	_____
Hepatitis B (once)	_____	**Polio (once)**	_____
Typhoid (Oral 5 yr./Inject 2 yr.)	_____	**Yellow Fever (10 years)**	_____

Based upon the following website:
wwwnc.cdc.gov/travel/destinations/list.htm
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. TEAM MEMBERS ARE RESPONSIBLE FOR THEIR OWN MEDICAL EXPENSES. IN THE EVENT AN ILLNESS OR INJURY OCCURS DURING A CAMPAIGN, YOU MAY NEED TO WORK WITH YOUR HEALTH INSURANCE PROVIDER. YOUR TEAM LEADER WILL BE GIVEN A COPY OF THIS FORM.

_____ _____

Signature of Applicant Date of Signature