CAPITOL CITY MEDICAL TEAMS EMERGENCY FORM

(form revised 6-6-18)

Complete this form before your medical trip. If you have questions, contact Eric Miller at (503) 378-7343 or at the email below. 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 CONTACTS AND THEIR PHONE NUMBERS

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

Limitations:
Allergies:
Medications:

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

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

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.

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Signature of Team Member Date of Signature