

GO, INC. MEDICAL FORM
(PLEASE PRINT USING BLACK PEN)

Full Legal Name _____ Birthdate _____ Age (at time of trip) _____

Street Address _____

City _____ State _____ Zip Code: _____

Passport Number & Issue Date _____

Emergency Contact Information

First & Last Name _____ Phone Number _____

Street Address _____ Email _____

Insurance Carrier _____ **Phone** _____

Name of Insured _____

Policy number _____ **Group Number** _____

Please include PHOTO COPY of insurance card (front/back). Thank you.

I have no insurance and assume any and all medical costs

Immunizations Tetanus yes (date _____) no

Hepatitis A yes (date _____) no

Typhoid yes (date _____) no

If you answer no, you are assuming all responsibilities if contracted on the trip. Please initial here _____

List allergies and reactions

None

List All Medications Taken Regularly

None

OTHER MEDICAL PROBLEMS (please check)

Diabetes Fainting Spells Epilepsy Hepatitis High Blood Pressure None

Other _____

Go, Inc. reserves the right as an organization to deny an individual's participation on a trip if there is concern about the individual's physical safety or the safety of the team.

***Required: Evacuation Insurance**

Insurance Carrier _____ Phone _____

Policy Number _____ Group Number _____

By signing this form I authorize the minister or sponsor of this activity or any Go Inc. Board member, in the event I cannot be reached by phone, to give consent to a physician and/or hospital for emergency medical or surgical treatment while on this trip. It is understood that I will assume any financial responsibility for any expense that may be incurred for said emergency treatment.

Participant signature: _____