

Volunteer Medical Information

Low Country Ministries

Name: _____ Age: _____
Address: _____ Phone: _____
S.S.# _____
Parents' Names: _____ Phone: _____
Parent's Address: _____

Daytime Location of Parents

Phone: _____
Phone: _____
Phone: _____

Family Physician: _____

Are you covered by health insurance? _____ Yes _____ No

Health Insurance Company: _____

Policy Number: _____

Are you in generally good health? _____

Are you allergic to any medicines or drugs? _____

What?

Are you allergic to any food? _____

What?

Do you have any other allergies? _____

What?

Have you been exposed to any contagious disease in the last six months? _____

What?

Do you have an updated tetanus shot? _____ Have you had your appendix removed? _____

Please list any medication you take on a regular basis or are now taking?

Is there any other medical information you feel we need to know about?

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