



North Country Mission of Hope

Working Together to Improve Lives

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MEDICAL INSURANCE AND EMERGENCY CONTACT INFORMATION

Participant Name _____
(Last) (First) (MI)

Date of Birth: _____ M _____ D _____ Y
Gender: M _____ F _____

Allergies (Medicine, food, etc.): _____

Special dietary needs: _____

List any medications being taken: _____

Physical impairments: _____

Family Physician: _____

Address: _____

Phone: _____ (_____) _____

Name of Insurance Carrier: _____ Policy No.: _____

Social Security Number of Policy Member (i.e. parent): _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Address _____
(Street/PO Box) City State Postal/Zip Code

Phone (Daytime) _____ (_____) _____ (Evening) _____ (_____) _____

Email _____

I, _____, hereby authorize North Country Mission of Hope Director, Sr. Debbie Blow, OP and/or members of the Leadership Team and members of the Medical Team, to seek and authorize emergency medical Treatment for my child, _____, or for myself _____ While on trip(s) to Nicaragua. This authorization also includes traveling to and from Nicaragua.

Signature(s) of Volunteer and/or Parent/Guardian: _____ Date _____

**Please attach a copy of your
Insurance Card**

THIS FORM MUST BE NOTARIZED