____

PRINT: Last Name, First Name

North Country Mission of Hope SM

Working Together to Improve Lives

3452 Route 22, Peru, NY 12972
Office: 518-643-5572
Cell: 518-572-4246

DSHope2@charter.net
www.ncmissionofhope.org

MEDICAL INSURANCE AND EMERGENCY CONTACT INFORMATION

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

Date of Birth: ____ ____ ____ Gender: M____ F___
Month Day Year

Allergies (Medicine, food, etc)____

Special Dietary Needs:____

List any medications being taken: ____

Physical Impairments/Psychological or Emotional needs:____

Family Physician: ____

Address:____

Phone: ( )____

Name of Insurance Carrier: ____Policy No.:_________ _ _____________

Social Security Number of Policy Holder (i.e.parent) ________________________________ **ATTACH COPY OF INS. CARD**

EMERGENCY CONTACT:

Name____ ____Relationship_____________________________

Address ____City____ ________________State_____ Zip___________
(Street/PO Box)

Phone (daytime) ( )___________________________________Evening( )________________________________

E-Mail____

I, ____,hereby authorize North Country Mission of Hope Director, Sr. Debbie Blow,O.P. 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________________________

____

THIS FORM MUST BE NOTARIZED

Revised October 2020