AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize my physician to release the medical information listed below, to OMS International or Men For Missions International, the laymen's voice of OMS, for the express purpose of participating in a missions assignment or team.

My doctor's name:____ Phone: (_____)-_____-______

Doctor's address:____ City: ______________________

Present medical Insurance Co:______________________________________ Policy#:____________________

Applicant's signature:____ Date: ______/______/______
month day year

MEDICAL STATEMENT BY PHYSICIAN

PATIENTS NAME:____ AGE:_____________

ADDRESS:____ CITY:______________________

Please answer the following questions with the most recent information, regarding the above patient:

MEDICAL EXAMINATION:______/______/______ month day year

POLIO/TETANUS:______/______/______ month day year

RESTRICTIONS ON ACTIVITIES: YES☐ NO☐ ____
If yes, explain

RESTRICTION ON TRAVEL: YES☐ NO☐ ____
If yes, explain

SPECIAL MEDICAL NEEDS: YES☐ NO☐ ____
If yes, explain

ANY PHYSICAL, MENTAL, NEUROLOGICAL, OR PSYCHOLOGICAL CONDITIONS: ______________

____
Please explain condition if existing

ANY MEDICAL CONDITIONS OF WHICH AN ATTENDING DOCTOR SHOULD BE AWARE: ________

____
Please explain condition if existing

LIST MEDICATIONS BEING TAKEN: ____

DO YOU KNOW THE TYPE OF TRAVEL THIS PATIENT IS PLANNING: YES☐ NO☐

OTHER INOCULATIONS AND/OR ANTI-MALARIAL MEDICATION ADMINISTERED:______________

____

Dr's SIGNATURE: ____, M.D. DATE: ______/______/______
month day year