

SUPPLEMENTAL HEALTH INFORMATION

Name: _____ Date: _____

List any existing health conditions that may require treatment (e.g. asthma, diabetes, migraines):

List all food allergies and type of reaction:

List all drug allergies and drug intolerances and type of reaction:

List dates of your most recent vaccines for the following:

Vaccine	Date
*MMR (Mumps, measles, rubella)	_____
*Tetanus	_____
**Hepatitis A	_____
**Hepatitis B	_____

*Vaccines required for mission trip

**Vaccines strongly recommended for mission trip

Do you wear contacts? Yes No

Parent's e-mail address: _____