Nomads of Hope
follow your heart change the world

Health Profile

Trip Participant

Name				Date of Birth		
Address				Phone		
City	State	Zip Code		Age	Grade	Gender

Medical Information

Medical Concerns. Any condition we should be aware of including allergies

List all medications you take including; prescription, over the counter, and vitamins

By checking items on this list I give permission to the Trip Leaders to administer those specific medications to my child. I understand that only the medications that I check or list will be available for my child and they will be administered in compliance with labeled instructions.

	Acetaminophen (Tylenol)		Ibuprofen (Motrin)		Other
	Antacid Tablets		Pseudoephedrine Hydrochloride		Other
	Cough Drops		Laxative / Fiber Supplement		Other
	Diphenhydramine HCl (Benadryl)		Triple Antibiotic Ointment (Bacitracin)		Other

Emergency Contact Information

Contact 1		Contact 2	
Name		Name	
Phone	Phone	Phone	Phone
Relationship		Relationship	
Dr.'s Name		Dr.'s Phone 1	Dr.'s Phone 2

Authorized Signatures

For participants under the age of 18: In the event of an emergency and I cannot be reached I give the Trip Leaders permission to seek and obtain medical attention for my child named above on this form ☐ I have provided a copy of my health insurance card or other proof of health insurance

Signature Date

Printed Name

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