

Disaster Ministry  
Iowa Conference of The United Methodist Church  
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**Medical Information For Individual Volunteers  
(Every Volunteer Needs to Complete This Form)**

Please complete the following and give it to your mission leader. The mission team leader should retain this form **ON SITE** to use in case of an emergency.

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

Name of Contact Person & What Relationship to volunteer: \_\_\_\_\_

Phone Number of Contact Person: \_\_\_\_\_

Blood type: \_\_\_\_\_ Allergies: \_\_\_\_\_

I am diabetic: Yes No I have a history of seizures: Yes No  
Information about any prescriptions currently taking: \_\_\_\_\_

Please provide any pertinent health information: \_\_\_\_\_

Physical limitations or concerns: \_\_\_\_\_

My health insurance company is: \_\_\_\_\_

Policy number: \_\_\_\_\_

I consider myself healthy enough to fulfill my responsibilities on the mission team  
Yes No

Volunteer Signature: \_\_\_\_\_ Date: \_\_\_\_\_