Medical / Emergency Contact Information

Tijuana Christian Mission ♦ P.O. Box 437930 ♦ San Ysidro, CA 92143 ♦ Office: 619-240-8650
♦ www.tijuanachristianmission.org ♦ Email: TCM@tijuanachristianmission.org ♦

Part 1: Participant's Contact Information

Name _____ Birthdate _____ Age _____

Address _____

City _____ State/Prov _____ ZIP Code _____

Email _____ Phone _____

Part 2: Emergency Contact Information

Name _____ Relation to Participant _____

Address _____

City _____ State/Prov _____ ZIP Code _____

Home/Work/Cell Phone _____

If Participant is under 18, please complete the following:

Father's/Guardian's Name _____

Address _____

City _____ State/Prov _____ ZIP Code _____

Home/Work/Cell Phone _____

Mother's/Guardian's Name _____

Address _____

City _____ State/Prov _____ ZIP Code _____

Home/Work/Cell Phone _____

Part 3: Medical Information

Answer the following questions to the best of your knowledge. Attach an extra sheet if you need more space.

Please list any physical limitations, handicaps, or medical conditions that you have. _____

_____

Please list any allergies that you have (environmental, food, medication, etc.). _____

_____

Please list any dietary restrictions that you have. _____

_____

Please list any medications you are taking (prescription or over-the-counter). _____

_____

Do you smoke? Yes / No Do you drink alcohol? Yes / No Are you currently under a doctor's care? Yes / No

If you answered "Yes" to any of these questions, please explain on a separate sheet.

To the best of my knowledge, I certify that all of the above information is true and accurate.

Participant's Signature _____ Date _____

If under 18, Parent's/Guardian's Signature _____