



**First United Methodist Church**  
Lakeland, Florida 863-686-3163  
**MEDICAL INFORMATION FOR INDIVIDUAL VOLUNTEERS**  
(Every Volunteer Needs to Fill Out This Form)

**Return the completed form to Carol Marsh, or your Volunteer Team Leader.**  
**The Team Leader should retain a copy ON SITE to use in case of emergency.**

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
2. Blood Type: \_\_\_\_\_
3. Information about any prescriptions you are currently taking:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Allergies: \_\_\_\_\_
5. Name of Contact Person: \_\_\_\_\_  
  - A. Street Address: \_\_\_\_\_
  - B. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
  - C. Phone: Work: \_\_\_\_\_ Home: \_\_\_\_\_ Cell \_\_\_\_\_
  - D. Relationship to volunteer: \_\_\_\_\_
6. Health Insurance Company Information: \_\_\_\_\_  
  - A. Policy Number: \_\_\_\_\_
7. Physical limitations or concerns:  
\_\_\_\_\_  
\_\_\_\_\_
8. I am diabetic: Yes: \_\_\_\_\_ No: \_\_\_\_\_
9. I have a history of seizures: Yes: \_\_\_\_\_ No: \_\_\_\_\_
10. Please provide other helpful health information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
11. I consider myself healthy enough to fulfill my responsibilities on the mission team: Yes: \_\_\_ No: \_\_\_

\_\_\_\_\_  
Signature & Date