



CAN-DO MISSIONS' REGISTRATION FORM PARTICIPANT

General Information

Name: _____ Birth Date: _____ Age: ____ M ____ F ____
Address: _____ City: _____ State: ____ Zip: _____
Home Ph.: _____ Work Ph.: _____ Cell Ph.: _____
E-mail: _____ Passport No: _____ (Int'l trip only)
Church: _____ City: _____ Languages Spoken: _____
Prior CAN-DO Missions' experience: Yes No T-Shirt Size: S M L XL XXL XXXL
Missions Site: _____ Date: _____

Medical & Health Insurance Information

Check the appropriate blank if you have ever had any of the following, and explain under remarks, indicating the number:

Allergies (including drug) Asthma Bee/Wasp Reaction Diabetes Epilepsy High Blood Pressure
 Dizziness of Fainting Hay Fever Heart Trouble Operation in last year Penicillin Allergy
 Pregnant Physical Handicap Regular Medication Respiratory Problems Any Problem not listed

List: _____ Last Tetanus Shot Date: _____

Be sure to take an ample supply of any regular medication for your length of service and a written prescription form a doctor.

IN CASE OF EMERGENCY CONTACT: _____ Relation to you: _____

Daytime Ph: _____ Evening Ph: _____ Cell Ph: _____

Address: _____ City: _____ State: ____ Zip: _____

All participants **MUST** have current Health Insurance for Domestic trips.

Please place copy of your Health Insurance Card here.

Front of card

Back of card