FEEDMYLAMBS MINISTRY

HAITI VOLUTEERS
MEDICAL INFORMATION

Name: ____

Allergies: ____

Blood Type: ____

Current Medical Condition(s): ____

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Current Medications (including over the counter medications): ____

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____

Any Recent Surgery: ____

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I confirm that the information provided above is complete to the best of my knowledge and recollection.

Signed ______________________________ Date ______________________________