

MINISTRY TO MINISTERS SABBATICAL PROGRAM MEDICAL INFORMATION FORM



Last	First	M.I.
MERGENCY INFORMATI	ON : In case of an emergency, ple	ase contact:
Family Member:		
Relationship:		
Day Phone: ()	Evening phone: ()
Day Phone: ()	Evening phone: ()
Subscriber:	*****Please be sure to bring your insur	
Carrier:		
Group#:	Policy#: for proper care in case of emergency. All inform	
[Note: Full disclosure is important f	or proper care in case of emergency. All infor	mation is kept confidential.
MEDICATIONS YOU REGULAI 1.		
How long have you taken this m	For:edication?	
	For:	
How long have you taken this m	edication?	
3	For:	
How long have you taken this m	edication?	
4	For:	
How long have you taken this m	edication?	
	es, heart, respiratory, etc.)	
1 2		
3		
4.		
Date of last TETANUS injection (must include month and year)	
COVID-19 vaccination (must i	 nclude name of vaccine and date(s) of	inoculation(s))
		(-//
Special Dietary or Housing Ne	odc:	



MINISTRY TO MINISTERS

Sabbatical Program - Oblate School of Theology



MEDICAL INFORMATION FORM (page 2)

All participants are required to complete each section. Registration will not be finalized without these forms. The information is strictly for the use of the Ministry to Ministers Program and will not be released without your knowledge or consent.

Have you ever had:	Υ	N
Scarlet Fever		
Measles		
German Measles		1
Mumps		
Chicken Pox		
Malaria Malaria		
/enereal Disease		
Tuberculosis		
AIDS		
Surgeries:	Date	
1.		
2.		
3.		
4.		
Has your physical activity been restricted during the past five years?		
(Give reasons and durations)		
Have you ever had illness or injury or been hospitalized other than noted above? (give details)		
Have you been treated by a psychiatrist, psychoanalyst, psychologist, or similar practitioner for any mental, emotional, or nervous disorder within the last two years?		
Have ever been hospitalized for any mental, emotional or nervous disorder or placed in a mental health facility?		
Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years (other than routine checkups)?		
SIGNATURE DATE		

Physician's Name (Please print)	
Address	Telephone number
City, State, Zip Code	Date