MEDICAL INFORMATION SHEET

PLEASE PRINT ALL INFORMATION

NAME OF TRAVELER:

_____

Last in Capitals First Middle

HOME ADDRESS: _____

Street City, State, Zip

HOME PHONE: _____ BUSINESS PHONE: _____

DOCTOR'S NAME: _____ PHONE: _____

In case of an emergency and no answer at home, please call:

_____

Last name Relation Phone

Will the traveler be taking any medications? _____ Yes _____ No

If yes, what medication?

Dosage_____ Medication times _____

Please note that all medications MUST be in the original container and MUST have person's name on the container. Carry all over-the-counter medications in the ORIGINAL container.

Does the participant have any allergies? _____ Yes _____ No

If yes, please indicate to what:

Food (s): _____

Medication: _____

Other: _____

PERMISSION TO TRAVEL AND TO SEEK MEDICAL TREATMENT RELEASE:

I _____ do hereby give my consent for _____ (group leader) to seek emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve life, limb, or well being.

_____ _____

Signature Date

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PLEASE GIVE THIS FORM ALONG WITH A COPY OF YOUR PASSPORT AND A COPY OF YOUR INSURANCE CARD (FRONT AND BACK) TO YOUR COACH.