

MEDICAL INFORMATION FORM

Name: _____

Address: _____

Telephone: _____ cell: _____

Date of birth: _____

In the event of an emergency, please notify:

Name: _____ relationship _____

Address: _____

Telephone _____ cell _____

List any medical restrictions or handicaps for which we need to make provisions:

List any medications you are presently taking:

List any allergies:

Name of your health insurance company: _____

Policy#: _____ Name of policy holder: _____

Does this policy cover travel outside the USA? _____

Do you have Travel insurance? _____

Your physician's name: _____ telephone: _____

Attach a photocopy of your insurance card or a copy of your traveler's health insurance policy.