MEDICAL INFORMATION

Name: ______________________________

Emergency Contact(s): ______________________________

Relationship: ____________________ Phone(s): ____________________

Medical Insurance Information

Company: ____________________ Policy type: ____________________

Phone: ____________________ Policy No.: ____________________

Medical Information

List all prescription medications(s) you will bring on this trip (use back if necessary):

____

For what condition(s)? ______________________________

Date of last tetanus shot (this must be within ten years): ____________________

Date of Hepatitis A inoculation (not required, but recommended: ____________________

List any physical disabilities or limitations: ______________________________

List any known allergies and reactions: ______________________________

List any major illnesses in the past year: ______________________________

Have you fainted or passed out? ☐ Yes ☐ No When? ____________________

Why: ______________________________

Do you have any eating disorders? ☐ Yes ☐ No

If yes, have you received counseling? ☐ Yes ☐ No

______________________________ ____________________

Signature Date