TRAVEL ABROAD MEDICAL PROFILE AND CONSENT FOR CARE
CONFIDENTIAL

After completion, give a sealed envelope containing the form to your program director. Include up-to-date copy of immunizations history.

Name: _____

M __ F____

Home Phone: _____

Address: _____

Date of Birth: _____

Social Security Number: _____

In Case of Emergency Notify:

Name: _____

Relationship to you: _____

Phone:

Name:_____

Relationship to you: _____

Phone: _____

Personal Physician: _____

Name: _____

Phone: _____

Address: _____

Health Insurance:

Company: _____

Policy #: _____

Group #: _____

Phone: _____

Address: _____

Blood Type (if known) _____

Allergies and Drug Reactions: (describe type of reaction)

Current Medications:
(Include exact dosage and reason for medication)

Current Medical Problems or Health concerns:
(List ALL problems whether or not they affect your activity)
Past Illness/Hospitalizations/Surgery:
(List ALL significant past illness, and all hospitalizations and surgeries; give dates)

Have you ever had chickenpox? _____Yes ____No

_____ _____
Signature Date

_____
Printed Names

_____
Guardian's Signature, if under 18 years of age