TRAVEL ABROAD MEDICAL PROFILE AND CONSENT FOR CARE
CONFIDENTIAL

After completion, give sealed envelope containing the form to trip leader. 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:

1. Name: __________________________________

Relationship to you: ______________________

Phone: __________________________________

2. Name: __________________________________

Relationship to you: ______________________

Phone: __________________________________

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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)

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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 Name

____
Co-Signature of parent or guardian
if student is under 18 years of age

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