



MEDICAL INFORMATION

Name (as it appears on your passport / Driver's License): _____

Name of Insurance Company: _____

Insurance Identification #: _____

Insurance Phone Number: (_____) _____ - _____

Name of Policy Holder: _____ Relationship to Policy Holder: _____

If other than yourself, please give the following information of the person that carries the insurance:

Address : Street &/or PO Box _____

City _____ State _____ Zip code _____ Phone number (_____) _____ - _____

1. Please list any important information that would be helpful for medical personnel to know, including *physical disabilities or health problems* you have: _____ None:

2. Please list any important *medications* that would be helpful for medical personnel to know (i.e. blood thinners, heart medication, allergies to medications): _____ None:

Medication:

Dosage:

3. Do you have any *allergies* to medications or other substances? Yes No If yes, please list allergies: _____

4. Please list any *special needs* regarding diet or sleeping accommodations: _____

5. Do you have an up-to-date **tetanus** shot? Yes No

In the space below, photocopy the **front of your Insurance ID Card** and the **front of your drivers license** or another photo ID.