

Adult Emergency Medical Information **Name:** _____

The following information is requested, **not required**, for your protection in the event of a medical emergency. To protect your privacy, put this in a sealed envelope with your name on the outside and give to the TripMaster on the day of departure. If emergency medical care is required and you are unable to communicate, the information will be given to the medical provider. At the end of the trip, please retrieve the envelope from the TripMaster.

Medications currently taking _____

Medical condition requiring special care _____
(i.e. ADHD, Asthma, Convulsions, Heart trouble, Contact lenses, Diabetes, Fainting spells, Bleeding disorders, High blood pressure, Dentures)

Allergies _____
(i.e. Allergy to a medicine, foods, plants, animals, or insect toxin)

Other _____

Physician _____ Phone _____

Medical Insurance Information:

Company: _____ Policy Number: _____

Emergency Contact:

Name: _____ Phone: _____

Name: _____ Phone: _____

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