TRAVEL ABROAD MEDICAL PROFILE AND CONSENT FOR CARE
CONFIDENTIAL

After completion, **give sealed envelope** containing the form to the trip leader. **This envelope will not be opened unless an emergency** has occurred to the participant. Students are suggested to keep an 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: _____

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, health concerns, or any infectious diseases:
(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 Name

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