Health Form

Trip Title	Trip Date
Name	Age
Date of last Physical Exam	Last Tetanus Shot
Height	Weight
B/P	Blood Type

How do you appraise your current health? ___ Excellent ___ Good ___ Poor ___

Do you have a condition that requires a special diet? If so, please explain:

_____

Have you ever been treated for any major health problems? If so, please explain:

_____

Do you have any chronic or recurring health problems? If so, please explain:

_____

Are you currently taking any medications? If so, please specify drug and reason:

_____

Will you be taking this medicine on your trip? ____ Yes ____ No

Do you have any allergies? If so, please specify:

_____

Have you ever suffered from or received treatment for emotional or mental illness? If so, please explain:

_____

Do you snore? ____ Yes ____ No

Emergency Contact Person:

Name: _____ Relationship_____
Home Phone_____ Work Phone_____
Address_____
__

In case of an emergency, I hereby authorize any necessary medical treatment by the appropriate medical personnel in the country that I am visiting.

Signature_____ Date_____
Printed Name_____