



**SHORT-TERM TRIP
EMERGENCY & MEDICAL INFORMATION**

Participant's Name _____

Date: _____

Parents/Spouse _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____

Emergency contact other than parents/spouse _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____

Medical Insurance Company _____

Insurance Policy Holder _____ Insurance Policy Number _____

**** IMPORTANT: Please submit a front and back copy of your medical insurance card. ****

Family Doctor _____ Phone _____

Address _____

City _____ State _____ Zip _____

Describe any health problems: _____

List current medications: _____

List any chronic diseases or allergies: _____

Do you wear glasses or contacts? Glasses _____ Contacts _____