Personal Medical History Form

(This information is confidential and will only be accessed if necessary, in the case of an emergency or for your convenience while traveilng.)

Please Print

Name: _____ Date of Birth: _____

Address: _____ Zip Code: _____

Medical Emergency Contact

Name: _____

Relationship: _____

Phone: _____

Secondary Contact

Name: _____

Relationship: _____

Phone: _____

1. Please list medical conditions you are currently being treated for:
   _____
   _____
   _____
2. Please list medications you are currently taking:
   _____
   _____
   _____
   _____
3. List any allergies you may have:
   _____
   _____
4. Covid Vaccinated (circle): Yes No
5. (Recommended) Tetatus Vaccine date: _____
6. Primary care provider:_____ Phone: _____
7. Please make sure you pack the appropriate number of personal medications you will need for the duration of your trip.
8. Copy of Passport Attached? (circle): Yes No Passport number: _____

9. Leave a copy of your passport with someone who you can easily reach if you should need it.

10. This information given herein is confidential and will not be utilized for purposes other than providing appropriate medical care in an emergency.

Signature: _____ Date: _____

INTERNAL USE ONLY

Review Date: _____ Initials: _____