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<http://www.GuatemalaVillageHealth.org>

EMERGENCY CONTACT, MEDICAL HISTORY & INSURANCE

PLEASE PRINT:

Please register me for the trip to Guatemala on (date): _____

NAME (AS IT APPEARS ON YOUR PASSPORT)				
ADDRESS (HOME)	CITY	STATE	ZIP CODE	PHONE NUMBER

MEDICAL HISTORY:

LIST KNOWN ALLERGIES: (MEDICINES, ETC.)		
LIST SIGNIFICANT MEDICAL PROBLEMS		
MEDICATIONS TAKEN REGULARLY		
DRUG	DOSE	FREQUENCY
PRIMARY PHYSICIAN NAME	SPECIALTY	PHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

EMERGENCY CONTACT:

NAME	RELATIONSHIP	PHONE NUMBER
ADDRESS	CITY	STATE ZIP CODE

MEDICAL INSURANCE:

INSURANCE PROVIDER	POLICYHOLDER NAME	PHONE NUMBER
ID-NUMBER	POLICY NUMBER	

TRAVEL EVACUATION INSURANCE:

INSURANCE PROVIDER	POLICYHOLDER NAME	PHONE NUMBER
ID-NUMBER	POLICY NUMBER	EXPIRATION DATE

X _____
 SIGNATURE DATE