



## MEDICAL FORM

A copy of this form from ALL PARTICIPANTS must be turned in to your GROUP LEADER before traveling, by the date specified. DO NOT turn this form in to Initiatives International.

*In case of an emergency, the following is an accurate record of my medical information:*

Name: \_\_\_\_\_

Parent/Guardian names (for minors): \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of alternate contact in case of emergency: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Contract/Policy#: \_\_\_\_\_

*[Please attach a copy of your health insurance card (front and back). This information is relevant to those periods of your travel which are within the U.S. Your international travel is covered by insurance provided by Initiatives International.]*

Previous surgery: \_\_\_\_\_

Taking medication(s): No \_\_\_\_\_ Yes \_\_\_\_\_ Name of Medication(s): \_\_\_\_\_

Asthma: No \_\_\_\_\_ Yes \_\_\_\_\_ Current Treatment: \_\_\_\_\_

Allergies: No \_\_\_\_\_ Yes \_\_\_\_\_ Current Treatment: \_\_\_\_\_

Tetanus shot: (last administered): \_\_\_\_\_

Vegetarian/vegan or other diet concerns \_\_\_\_\_

Other medical conditions or special instructions: \_\_\_\_\_

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