

<date>

PERSONAL INFORMATION (please print clearly)

Information sections above the gray line are required. Personal medical information and the Authorization are optional.

IDENTIFICATION			
Name:		Date of Birth	Age Sex
Home Street Address		City	State Zip
Home Phone		Cell Phone	
Passport Number <i>Attach copy with photo page</i>		Date Issued	
EMERGENCY NOTIFICATION			
Name		Home/Cell Phone	
Relationship		Work Phone	
Name		Home/Cell Phone	
Relationship		Work Phone	
Personal Physician		Office Phone	
Medical Insurance Company	Policy Holder	Policy Number	International Travel Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No
FOOD RESTRICTIONS (vegetarian, kosher, allergies, etc)			
MEDICAL Existing Medical Conditions (asthma, diabetes, etc)			
Allergies (medications, insects, plants)			
Medications you are currently taking and condition(s) for which they are prescribed			
Are these medications kept on you at all times: Y N If not, where are they kept? <i>You should have a written prescription with you in case your medication must be replaced.</i>			
AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT			
In case of medical emergency, I give my advance written permission to the group's advisors to seek and secure proper medical treatment on my behalf and to the licensed health practitioner to perform necessary diagnostic tests and treatments.			
Signature		Date	

Personal medical information will be separated and destroyed at the end of the class.