



GlobalDentalExpeditions

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Health and Emergency Contact Form

Name: _____ Birth Date: _____ Sex: F / M

Home Tel: _____ Age: _____ Companion Name (if any): _____

Do you have any **MEDICAL CONDITION(s)** - such as allergies, heart disease, emphysema, diabetes, seizures, depression, injuries, recent surgery, etc - important to know in case of emergency? ___N ___Y
If "yes", please specify condition(s) _____

Do you have any **RESTRICTION** - such as impaired vision, hearing, breathing, mobility, etc? ___N ___Y
If "yes", please specify restriction(s) _____

Do you have any other respiratory ailment? ___N ___Y
If "yes" please specify condition _____

Do you have a history of mental or emotional instability? ___N ___Y

Are you currently under the care of a physician for any of the above mentioned conditions? ___N ___Y
If "yes" please explain _____

Do the medical condition(s) and/or restrictions noted require special arrangements, equipment, or assistance for you to participate in an active schedule described in your itinerary for the project in which you are enrolled?
___N ___Y If "yes" please specify _____

Do you require any prescription medications on a regular basis in order to function effectively? ___N ___Y
If "yes" please list the names and reasons for taking said medications or write "NONE":

Personal Physician _____ Telephone Number _____
(24-hr emergency number if available)

Do you have your own personal medical (accidental/illness) insurance coverage? ___N ___Y Please Specify:

Name of Insurance Company _____ *Policy Number*

Person to notify in the event of accident or medical emergency (*Someone other than your traveling companion*):

Name _____ Relationship _____

Address _____

Telephone number(s) to call: Home _____ Work _____

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Signed _____ Date _____

Printed Name _____