

MEDICAL HISTORY

Patient Full Name _____ Birth Date _____

Passport Number _____

Immunization Record with Dates:

	1 st	2 nd	3 rd
Hepatitis A	_____	_____	
Hepatitis B	_____	_____	_____
Tetanus	_____		
Other	_____		

Prophylactic Medications: (Recommended medication: Cipro)

Name of Medicine	Medicine Obtained	
1. _____	Yes	No
2. _____	Yes	No

Emergency Contact:

<u>Contact #1</u>	<u>Contact #2</u>
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Contact #: _____	Contact #: _____

Insurance Carrier: _____ I.D. Number: _____

This form is due one month prior to trip departure.