



HEALTH & EMERGENCY INFORMATION FORM



(One form must be completed for each participant. (You may fill in the information that is the same on one form, copy it and then fill in the personal information for each participant.)

RETURN EACH FORM WITH AN ORIGINAL SIGNATURE PRIOR TO ARRIVAL.

TAMUG, Elderhostel Program, P.O. Box 1675, Galveston, Texas 77553-1675

PLEASE PRINT

LAST NAME	FIRST NAME	NAME YOU WANT ON YOUR NAME TAG	
STREET ADDRESS	CITY	STATE	ZIP
()	()		M F
HOME PHONE	CELL PHONE	DATE OF BIRTH	GENDER
E-MAIL ADDRESS			



HEALTH INFORMATION- Do you have any health conditions, legal arrangements or religious convictions that may affect your participation in the program or should be known prior to emergency medical treatment? (i.e., allergies, reaction to medication, chronic conditions etc.)

Please explain: _____



SPECIAL NEEDS INFORMATION- Do you have a physical handicap/special need (i.e., visual or hearing impaired, wheelchair, unable to climb stairs etc.) for which you will require special attention or accommodation?

Please explain & list your needs: _____



MEDICATIONS- Please list all medications you are currently taking: _____



EMERGENCY CONTACT INFORMATION- Whom should we notify in case of an accident or medical emergency? Please list an individual other than your traveling companion.

Name: _____ Relationship to you: _____

Day phone: () _____ Cell phone: () _____ Evening phone: () _____

STREET ADDRESS	CITY	STATE	ZIP
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INSURANCE (HEALTH & ACCIDENT) INFORMATION

Name of Insurance Company: _____ Policy/Group #: _____

Address of Insurance Company: _____

STREET ADDRESS	CITY	STATE	ZIP
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Insurance Company phone: () _____



INTERGENERATIONAL ELDERHOSTEL PARTICIPANTS ONLY:

Please complete the following information regarding grandchildren participating in the program with you.
(We must have this information for room assignments)

Name: _____ Gender: M F Age: _____

Name: _____ Gender: M F Age: _____