

Medical Form for InsignOut Journeys

Participant Name _____

Event _____

We do not provide any medical assistance or support on our tours. The Americans with Disabilities Act and other laws of the United States, individual states or there local jurisdictions do not apply as the tour is not in the United States. However, if a medical emergence were to arise on one of our events, we want to have available relevant information regarding any medical condition or limitations that you may have in the event that you are unable to communicate this information yourself personally. While we do not have the duty to provide emergency assistance, we want to be sure that local providers are provided with accurate information. This information will be available to your guides during the event who will keep it confidential unless there is a medical emergency. In this case your guide may provide this information to an attending care provider or emergency responder and/or use it to contact the people you list.

Medical Information:

List past or present physical or mental condition that will or may affect your ability to participate in this event. This would include mobility limitations, restrictions or limitations on physical exertions, impairment of any senses, cognition, heart difficulties or conditions, dietary restrictions, allergies, arthritis, physical or mental illnesses, chronic or acute diseases, substance additions or abuse. Please include any medications you are taking and the dosages. Be sure to bring all necessary medications with you on this event.

Physical or mental conditions: _____

Allergies: _____

Dietary restrictions: _____

Prescriptions medications Dosage/day Condition medication treats

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contacts:

Please list people not on the tour that you would want us to contact in the event of an emergency. This information will only be used if necessary.

Name _____ Relationship _____

Day phone w/country and or area code () _____ Eve _____

Email address _____

Physician Name: _____ Phone: _____

I represent that the above information is complete and accurate

Signature _____

Date _____

One form per participant