MEDICAL INFORMATION FORM – OBSIDIAN BUS TRIPS

(please print)

NAME: _____ CURRENT YEAR: _____

ADDRESS: _____ PHONE: _____

CITY/ST./ZIP: _____ EMAIL: _____

Name:_____ Date of Birth: _____
(as listed on insurance card)

Name of Insurance Company (if not on Medicare): _____

Policy Number: _____ Group ID Number: _____

OR

If on Medicare:

Medicare Number: _____ Do you have A_____B_____D_____

Supplemental Insurance Company: _____

Policy Number: _____Group:_____

You may submit copies of your cards instead of filling the above out.

Primary Care Physician: _____ Phone:_____

Do you have a living will? _____ Who has a copy?_____

EMERGENCY CONTACT PERSONS:

Name: _____ Phone: _____

Name: _____ Phone: _____

In the event you are unconscious contact: _____

Phone:_____, (he/she) has the authority to authorize my medical care.

List Medical information that would be helpful to an emergency team i.e., medications, allergies, pacemaker, lens implants, etc. You may submit your own copies of insurance cards and medical info.

_____

_____

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This form will remain sealed during the current year unless accessed for an emergency. Then it will be shredded.

Please mail the completed form to the trip registrar along with your trip payment.