American Trails West
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MEDICAL FORM

This side of the Medical Form is to be filled in by Parent or Guardian as completely as possible. Be sure to enter all the information asked for below, including traveler's name, trip name, medical insurance [please attach a photocopy of your Medical Insurance Card], credit card, parent or guardian address and phone numbers and two emergency contacts. Parent or Guardian must sign Authorization at bottom.

Traveler's Name ______________________ DOB __________ SSN __________ Trip Name __________

Home Address ____
(street) (city) (state) (zip)

Parent/Guardian ______________ Home Phone __________ Business Phone __________ Cell Phone __________

Medical Insurance ______________ Group # __________ Policy # ______________

Name of insured ______________________ Relationship to Traveler ______________

CREDIT CARD PAYMENT AUTHORIZATION (when medical facility does not accept insurance): I hereby authorize American Trails West and its representatives to charge medical treatment and medication for my child. American Trails West may only use this credit card for medical treatment and medication for the duration of the tour program.

Credit Card # ______________ Name on Card ______________ Expiration Date __________

IF PARENT OR GUARDIAN IS NOT AVAILABLE IN CASE OF EMERGENCY, PLEASE NOTIFY:

1. Name ______________________ Home Phone __________ Bus. Phone __________
(relationship)

Address ____

2. Name ______________________ Home Phone __________ Bus. Phone __________
(relationship)

Address ____

HEALTH HISTORY (CHECK & GIVE DATES):

Diseases

Ear Infections __________ Measles __________
Rheumatic Fever __________ Mumps __________
Diabetes __________ Mononucleosis __________
Convulsions __________ Chicken Pox __________

Allergies

To Food (specify) ______________
To Medicine (specify) ______________
Hay Fever __________ Insect __________
Asthma __________ Poison Ivy __________

Operations or Serious Injuries (List & give dates) ____

Chronic or Recurring Illnesses ____

Prescription Drugs Being Brought On Tour (List drug & purpose) ______________________________

PARENT'S AUTHORIZATION:

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed tour and trip activities except as noted by me and the examining physician. In the event I cannot be reached in an emergency I hereby give permission to the physician selected by the trip or tour staff to hospitalize, secure proper treatment, and to order injection, anesthesia or surgery for my child as named above. In the event that the Medical Insurance listed above is not accepted, I authorize use of the above credit card for payment of medical charges.

______________________________ ______________
(Signature of Parent or Guardian) *(Date)*

MEDICAL EXAMINATION - To be filled out by licensed physician. Note: An official "Doctor's Medical Form" may be clipped to this page (Please do not staple).

DO NOT LEAVE THIS FORM AT YOUR DOCTOR'S OFFICE. IT MUST BE RETURNED IN THE 6X9 ENVELOPE WITH ALL OTHER DOCUMENTS.

This examination should be performed within nine months of trip departure. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activity.

Code: Satisfactory
Not satisfactory (explain)
Not examined

Hgt. ____________ Wt. ____________ B.P. ____________

Eyes ______________________________

Glasses ______________________________

Ears ______________________________

Nose ______________________________

Throat ______________________________

Teeth ______________________________

Heart ______________________________

Lungs ______________________________

Abdomen ______________________________

Hernia ______________________________

Hgb. Test ______________ Urinalysis ______________

Extremities ______________________________

Posture (spine) ______________________________

Skin ______________________________

Allergy: ______________________________

Please specify a) To Food: ______________________________

b) To Medicine: ______________________________

General Appraisal: ______________________________

Inoculation History:

DT ____________ OPV ____________ MMR ____________

(For Females)

Has this person menstruated? ____________

If yes, is her menstrual history normal? ______________________________

Recommendations and restrictions while traveling:

Special Diet ______________________________

Special Medicine ______________________________ Is parent sending it? ______________________________

Swimming ______________________________

Strenuous activity ______________________________

Other ______________________________

____

____

I have examined the person herein described and have reviewed his or her health history. It is my opinion that he or she is physically able to engage in all trip activities, except as noted above.

Examining Physician ______________________________ *Date* ______________

Address ______________________________

City, State, Zip ______________________________

Telephone ______________________________