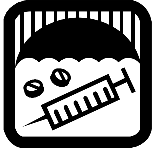
Please complete this form if you are traveling on tours of two or more days

(the form is required for your safety and is strictly confidential)



TRAVEL AUTHORIZATION & MEDICAL TREATMENT

(PLEASE PRINT)

NAME	BIRTH DATE	ALLERGIES (including food & medication), MEDICATIONS, ETC.

This document shall be presented to an immigration officer, physician, dentist or appropriate hospital representative at such time as requested or if unexpected medical, dentist, surgical care or hospitalization may be required. I/we, also assume ALL financial responsibility that may be incurred in the course of such care.

In case of emergency, please contact:

CONTACT 1		CONTACT 2	
NAME (PRINT)		NAME (PRINT)	
ADDRESS		ADDRESS	
HOME TELEPHONE		HOME TELEPHONE	
WORK TELEPHONE		WORK TELEPHONE	
SIGNATURE	DATE	SIGNATURE	DATE

HOSPITALIZATION COVERAGE FOR ABOVE NAMED

COMPANY OR GOVERNMENT PROGRAM	I.D. / CONTRACT NUMBER	CLAIMS OFFICE TELEPHONE #

FAMILY PHYSICIAN(S)

NAME & TELEPHONE NUMBER	NAME & TELEPHONE NUMBER

MEDICAL CONDITIONS

DIETARY NEEDS

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