HONDURAS COMPASSION PARTNERS
MEDICAL FORM

TRAVELER INFORMATION

Full Name: _____

E-Mail Address: : _____ Phone Number: _____

Street Address: _____ Mobile Number: _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Trip Dates: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact #1: _____ Day Phone Number: _____

Street Address: _____ Night Phone Number: _____

City: _____ State: _____ Zip Code: _____

Relationship to Traveler: _____ Email: _____

Emergency Contact #2: _____ Day Phone Number: _____

Street Address: _____ Night Phone Number: _____

City: _____ State: _____ Zip Code: _____

Relationship to Traveler: _____ Email: _____

HONDURAS COMPASSION PARTNERS

HONDURAS COMPASSION PARTNERS MEDICAL FORM

TRAVELER MEDICAL INFORMATION

Personal Physician: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Number: _____

Date of Last Tetanus Shot: _____
Allergies to Medicine or Food: _____
Existing Medical Conditions: _____
Physical Impairments: _____
Current Medications: _____

INSURANCE INFORMATION

Policy Number: _____

Health Insurance Company: _____ Group Number: _____

Street Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Agent Name: _____ Phone Number: _____

Primary Beneficiary Name: _____ Relationship: _____

Secondary Beneficiary Name: _____ Relationship: _____

Travelers are strongly encouraged to consult with their physician prior totravel to review vaccination and medical recommendations prior to the trip.