HEALTH/EMERGENCY INFORMATION FORM

This form must be completed before a WALLA trip and will be returned to you at the completion of this trip.
(Keep and use for the next trip)

_____

(Last Name) (First Name)

_____

(Address) (City)

- Do you have any health conditions (e.g., allergies, chronic conditions) or special circumstances (e.g., religious convictions arrangements) which may affect program participation or that we ought to know prior to emergency treatment? _____ If yes, please explain, on back of this sheet
- List medications (on back of this sheet)
- Can you use stairs without assistance? _____
- Can you stand to listen to short presentations? _____

Name someone other than a traveling companion, who can be notified in case of an accident or medical emergency.

_____

(Name and relationship) (Phone)

_____

Name of primary doctor and phone number

*****OPTIONAL*****
List name(s) of your health/accident insurance carrier and appropriate policy numbers

_____

(Name of carrier) (Policy Number)