

CONFIDENTIAL TRAVEL MEDICAL FORM

DATE _____

NAME _____ PHONE # _____

ADDRESS _____ CITY _____ ZIP _____

DATE OF BIRTH _____ BLOOD TYPE (if known) _____

1. PRIMARY MEDICAL INSURANCE COMPANY _____

2. IN CASE OF ILLNESS OR ACCIDENT, WHOM SHALL WE CONTACT?

NAME _____ PHONE (WORK) _____ (HOME) _____

3. IS THERE ANYTHING SPECIAL ABOUT YOUR HEALTH STATUS THAT WE SHOULD KNOW?

4. ARE YOU SUBJECT TO ANY OF THE FOLLOWING

ALLERGIES _____ DRUG ALLERGIES _____

5. ARE YOU ON ANY SPECIAL MEDICATION? _____ IF SO WHAT TYPE AND

DOSAGE _____

6. PLEASE PRINT YOUR DOCTOR'S NAME _____

PHONE _____

7. ARE YOU CELEBRATING A BIRTHDAY OR ANNIVERSARY WHILE WE ARE

ON TOUR? _____

8. Email if you wish for tour updates: _____

*****PLEASE BRING THIS FORM ON THE TOUR*****

MARYANKE TOUR & TRAVEL, INC.

1-800-542-3895