



REQUIRED EMERGENCY MEDICAL INFORMATION FORM

Please Return to Our Office At Least 2 Weeks Prior to Your Departure Date

Tour Name: _____ Departure Date: _____

Passenger Name: _____ Birthdate _____ / _____ / _____

Street Address: _____ City: _____ State _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Emergency Contact Name (Other than someone on same tour): _____

Relation to Traveler: _____ Home Phone: _____ Work/Cell Phone: _____

Medical Insurance Carrier _____

Primary Physician Name: _____ City: _____

Office Phone: _____ Other Phone: _____

How Would You Rate Your Current Health? Excellent _____ Good _____ Fair _____ Poor _____

What Medical Conditions, However Small, Do You Have? _____

Known Allergic Reactions To Any Foods Or Drugs: _____

Will You Be Taking Any Medication While On Tour? Yes _____ No _____ Does Any Require Refrigeration? Yes _____ No _____

Please List Medication (Generic Name), Dosage and Purpose Below:

Medicine _____ Dosage/Frequency: _____ Purpose: _____ Vital? Yes No

Medicine _____ Dosage/Frequency: _____ Purpose: _____ Vital? Yes No

Medicine _____ Dosage/Frequency: _____ Purpose: _____ Vital? Yes No

Medicine _____ Dosage/Frequency: _____ Purpose: _____ Vital? Yes No

(Use Reverse Side To List Any Additional Medications That You Take)

Additional Comments: _____

I hereby authorize Good Times Travel to provide this information to the Tour Director so that it is available to emergency personnel or medical professionals in the case of a medical emergency only.

Signature: _____ Date: _____

Thank you for taking the time to fill out and return this form to us.
Please be assured this information is confidential and is used only in case of a medical emergency.

Please See Reverse for Special Needs Requests

Please List Any Additional Medication (Generic Name), Dosage and Purpose Below:

Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No
Medicine _____	Dosage/Frequency: _____	Purpose: _____	Vital? Yes No

SPECIAL NEEDS REQUEST

If you have a special need(s), please fill out the following so that we may be able to better assist you prior to and on our journey.

Describe the nature of the disability/special need(s): _____

Will you be traveling with any special equipment (ie wheelchair, walker, cane, oxygen)? _____

Name of traveling companion responsible in assisting with special need(s): _____
(ie climbing steps, pushing wheelchair)

*Please note: travelers with wheelchairs must bring their own collapsible wheelchair or make their own arrangements at their destination. Motorized wheelchairs are not allowed on tour.

*Please note: all travelers must be able to walk/climb stairs unaided (including steps on/off motorcoach 6-7 times per day)

*Please note: Tour Directors and Motorcoach Drivers are not permitted to assist clients walking or climbing steps nor are they permitted to push wheelchairs.