American Trails West
92 Middle Neck Road
Great Neck, NY 11021

www.atwteentours.com

(800) 645-6260
NY State (516) 487-2800
Fax (516) 487-2855

info@atwteentours.com

MEDICAL FORM

This side of the Medical Form is to be filled in by Parent or Guardian as completely as possible. Be sure to enter all the information asked for below, including traveler's name, medical insurance [please attach a photocopy of your Medical Insurance Card], credit card, parent or guardian address and phone numbers and two emergency contacts. Parent or Guardian must sign Authorization at bottom.

Traveler's Name _____ DOB _____ SSN _____ Cell Phone _____

Home Address _____
(street) (city) (state) (zip)

Parent/Guardian _____ Home Phone _____ Bus.# _____ Cell # _____

Medical Insurance _____ Group # _____ Policy # _____

Name of insured _____ Relationship to Traveler _____

CREDIT CARD PAYMENT AUTHORIZATION (when medical facility does not accept insurance): I hereby authorize American Trails West and its representatives to charge medical treatment and medication for my child. American Trails West may only use this credit card for medical treatment and medication for the duration of the tour program.

Credit Card # _____ Name on Card _____ Expiration Date _____

IF PARENT OR GUARDIAN IS NOT AVAILABLE IN CASE OF EMERGENCY, PLEASE NOTIFY:

1. Name _____ Home Phone _____ Cell # _____
(relationship)

Address _____

2. Name _____ Home Phone _____ Cell # _____
(relationship)

Address _____

HEALTH HISTORY (CHECK & GIVE DATES):

Diseases				Allergies	
Ear Infections _____	Measles _____			To Food (specify) _____	
Rheumatic Fever _____	Mumps _____			To Medicine (specify) _____	
Diabetes _____	Mononucleosis _____			Hay Fever _____	Insect _____
Convulsions _____	Chicken Pox _____			Asthma _____	Poison Ivy _____

Operations or Serious Injuries (List & give dates) _____

_____

Chronic or Recurring Illnesses _____

_____

Prescription Drugs Being Brought On Tour (List drug & purpose) _____

_____

PARENT'S AUTHORIZATION:

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed tour and trip activities except as noted by me and the examining physician. In the event I cannot be reached in an emergency I hereby give permission to the physician selected by the trip or tour staff to hospitalize, secure proper treatment, and to order injection, anesthesia or surgery for my child as named above. In the event that the Medical Insurance listed above is not accepted, I authorize use of the above credit card for payment of medical charges.

(Signature of Parent or Guardian) *(Date)*

MEDICAL EXAMINATION - To be filled out by licensed physician. Note: An official "Doctor's Medical Form" may be clipped to this page (Please do not staple).

DO NOT LEAVE THIS FORM AT YOUR DOCTOR'S OFFICE. IT MUST BE RETURNED IN THE 6X9 ENVELOPE WITH ALL OTHER DOCUMENTS.

This examination should be performed within nine months of trip departure. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activity.

Code: Satisfactory
Not satisfactory (explain)
Not examined

Hgt. _____ Wt. _____ B.P. _____

Eyes _____

Glasses _____

Ears _____

Nose _____

Throat _____

Teeth _____

Heart _____

Lungs _____

Abdomen _____

Hernia _____

Hgb. Test _____ Urinalysis _____

Extremities _____

Posture (spine) _____

Skin _____

Allergy: _____

Please specify a) To Food: _____

b) To Medicine: _____

General Appraisal: _____

Inoculation History:

DT _____ OPV _____ MMR _____

(For Females)

Has this person menstruated? _____

If yes, is her menstrual history normal? _____

Recommendations and restrictions while traveling:

Special Diet _____

Special Medicine _____ Is parent sending it? _____

Swimming _____

Strenuous activity _____

Other _____

_____

_____

I have examined the person herein described and have reviewed his or her health history. It is my opinion that he or she is physically able to engage in all trip activities, except as noted above.

Examining Physician _____ *Date* _____

Address _____

City, State, Zip _____

Telephone _____