REID SAUNDERS ASSOCIATION
PO Box 4275, Salem, OR 97302

Medical Information Form

Name:	
Address:	
City/State/Zip:	
Home Phone:	Work Phone:
E-mail Address:	
Passport Number:	Exp. Date
Date of Birth:	

Medical History:

Please describe your personal medical history, including any special conditions or treatments, operation, etc. (if necessary, use back of form).

Medications:

List medications you are currently taking and will be bringing with you.

Allergies:

List any known allergies-natural, food based and or medicinal.

Special Dietary Needs:

If you have special dietary requirements that we should know about, please list. Keep in mind that we are at the mercy of the country.

Insurance Information

Name of Insurance Company:
Name of Policy Holder:
Insurance Numbers:
Name of Personal Physician:
Physician's Phone Number:

Emergency Contact Information

Name of Contact Person:
Relationship to Participant:
Phone Number: