Travel Abroad Medical Release Form

Participant Information

Full Name

Date of Birth

Passport Number

Home Address

Phone Number

Email

Emergency Contact

Name

Relationship

Phone Number

Medical Information

Primary Physician

Physician Phone Number

Allergies

Current Medications

Medical Conditions

Medical Release Authorization

I hereby authorize any licensed healthcare provider to provide any necessary medical treatment while traveling abroad. I further authorize release of medical information to necessary personnel.

Signature

Date