



## DOCUMENTS TO BE CARRIED BY TRAVELERS

\*Passport & Copy (Separately from Passport) \*List of medications \*Travel/health insurance cards

### **Personal Details**

Name as on Passport \_\_\_\_\_ Passport # \_\_\_\_\_

D. O. B.: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Contacts:

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

### **Next of kin to be contacted in an emergency**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Contacts:

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

### **Physician**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Contacts:

Work: \_\_\_\_\_ FAX: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Please provide health insurance carrier, phone number & policy number.

Do you have any allergies including drugs, foods, stings, band-Aids etc.?

Do you have any medical problem?

Do you take any prescribed medications?

Are you allergic to any foods or restrictions? Yes \_\_\_ No \_\_\_. If Yes, please list:

Are you disabled or limited in normal activities? Yes \_\_\_ No \_\_\_. If Yes, please explain:

**Prophylaxis:** We strongly recommend that you take chloroquine (500mg) for Malaria.

Do you intend to take it? Yes \_\_\_ No \_\_\_ (we can call prescription to your pharmacist if needed)

### **Waiver Of Responsibility:**

I, \_\_\_\_\_ along with members of my family, hereby voluntarily waive any claim for any reason against AHDH, Inc., the officers, leaders, staff members and sponsoring institutions.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian must sign for minors