GOOD TIMES TRAVEL
LOCAL DISCOVERIES • WORLDWIDE JOURNEYS

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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 your 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

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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.