

Elderhostel Health and Emergency Information

Please return form at least 7 days prior to begin date

This information will be kept confidential

Program Name _____ **Program Begin Date** _____

Last Name _____ First Name _____

Home Address _____

City _____ State _____ Zip _____

Telephone # _____ Date of Birth _____

Blood type _____

Do you have any health conditions (ie: allergies, chronic conditions) or special circumstances we ought to know prior to emergency treatment? Please explain: _____

Do you have any special needs (ie: walker, wheelchair, etc.)? Also, if you are over six feet tall, please note as we have a limited number of extra long beds available. Do you have any dietary restrictions we should be aware of? List below: _____

Please list any medications you are currently taking: _____

Is there any other information you feel we should be aware that pertains to your participation in this Elderhostel program? If yes, please explain.

Emergency Information: Other than your Elderhostel traveling companion, whom should we notify in case of an accident or medical emergency?

Name _____ Relationship _____

Telephone # _____ City, State _____

Health/Accident Insurance

Name of Carrier _____ Policy Number _____