Adult Traveler Emergency Medical Consent Form

Instructions: Please complete this form in full. This document authorizes medical providers to administer emergency medical treatment in the event that you are incapacitated or unable to provide consent during travel.

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1. Traveler Personal Information

Full Legal Name:	
Date of Birth (MM/DD/YYYY):	
Phone Number:	
Email Address:	
Home Address:	

2. Emergency Contact Information

Please designate a primary and secondary contact who can be reached in an emergency.

Primary Emergency Contact

Full Name:	
Relationship to Traveler:	
Primary Phone:	
Alternate Phone:	

Secondary Emergency Contact

Full Name:	
Relationship to Traveler:	
Primary Phone:	
Alternate Phone:	

3. Medical Insurance Information

Insurance Provider:	
Policy / ID Number:	
Group Number:	
Policy Holder Name:	

4. Traveler Health Profile

Known Medical Conditions (e.g., Diabetes, Asthma):	
Allergies (Food, Medication, Environmental):	
Current Medications & Dosages:	
Blood Type (if known):	
Primary Care Physician Name:	
Physician Phone Number:	

5. Consent and Authorization

In the event of a medical emergency during my travels, I, the undersigned adult traveler, hereby authorize emergency medical technicians, medical professionals, and hospital staff to perform any necessary diagnostic procedures, medical treatments, or surgical interventions in the event that I am unconscious, incapacitated, or otherwise unable to provide direct consent at the time treatment is required. I also authorize the release of my medical records and insurance information to medical providers as necessary for my care.

This consent shall remain in effect for the duration of my travel dates specified below.

Travel Start Date (MM/DD/YYYY): _____

Travel End Date (MM/DD/YYYY): _____

Traveler Signature (for print): _____

Printed Full Name: _____

Date Signed (MM/DD/YYYY): _____