



Family Travel Health Information Form

Individual Information

- **Full Legal Name (as on passport/ID):** _____
 - **Preferred Name (if different):** _____
 - **Date of Birth (MM/DD/YYYY):** _____
 - **Gender (optional):** _____
 - **Relationship to Family (if applicable):** _____
 - **Nationality / Citizenship:** _____
 - **Passport Number (optional):** _____
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Travel Details

- **Destination Country/Countries:** _____
 - **City/Region:** _____
 - **Travel Dates:** _____
 - **Purpose of Travel:** Vacation Work School Visiting Family Other
 - **Accommodations:** Hotel Rental Family/Friends Other
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Emergency Contacts

Primary Emergency Contact (Traveling or Home-Based) -

Name: _____

Relationship: _____

Phone (with country code): _____

Email: _____

Secondary Emergency Contact - Name:

Phone: _____

Primary Healthcare Information

- **Primary Care Provider:** _____

This medical view is intended to display certain health information entered by Primary Guardian or made available to a school and may not accurately reflect the full medical history. This summary is not intended to replace official health records or professional medical judgment. Please consult with your healthcare provider prior to making any health decisions related to your health.

- **Clinic / Practice Name:** _____
 - **Phone:** _____
 - **Preferred Hospital (Home Country):** _____
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Health Insurance & Travel Coverage

- **Health Insurance Provider:** _____
 - **Policy / Member ID:** _____
 - **Travel Medical Insurance Provider (if different):** _____
 - **Emergency Assistance Phone (24/7):** _____
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Medical Conditions

Check all that apply and provide details below.

- Asthma
- Severe Allergies / Anaphylaxis
- Diabetes
- Heart Condition
- Seizure Disorder
- Autoimmune Condition
- Mental Health Condition (anxiety, depression, etc.)
- Pregnancy
- Immunocompromised
- Other: _____

Condition Details / Triggers / Precautions:

Allergies & Adverse Reactions

- **Medication Allergies:** _____
- **Food Allergies:** _____
- **Insect / Environmental Allergies:** _____

Reaction Type (e.g., rash, swelling, breathing difficulty):

Current Medications

Include prescriptions, over-the-counter medications, vitamins, and supplements.

Medication Name	Dose / Strength	Frequency	Reason	Prescribing Provider	PRN (As Needed)
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency & Rescue Medications

- Epinephrine Auto-Injector
- Inhaler (e.g., Albuterol)
- Insulin / Glucagon
- Seizure Rescue Medication
- Other: _____

Instructions for Use:

Immunizations & Travel Vaccines

- Routine immunizations up to date
- COVID-19 (if applicable)
- Influenza
- Hepatitis A / B
- Typhoid
- Yellow Fever
- Other: _____

Date of Last Relevant Vaccine: _____

Blood Type & Special Medical Notes (If Known)

- **Blood Type:** _____
 - **Medical Devices (e.g., pacemaker, CGM, implants):** _____
 - **Special Care Instructions:** _____
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Accessibility & Assistance Needs

- Mobility assistance
- Vision or hearing assistance
- Dietary restrictions
- Requires caregiver support

Details: _____

Consent & Authorization (Optional but Recommended)

I authorize healthcare providers, emergency responders, airlines, and travel authorities to access and use this information for medical treatment in the event I am unable to communicate.

- **Name:** _____
 - **Signature:** _____
 - **Date:** _____
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Travel Health & Privacy Notice: This document is intended for emergency and continuity-of-care purposes during travel. Carry a digital and printed copy. Laws and medical practices vary by country; this form does not replace professional medical advice or official medical records.