

Travel Document: Medical Summary

Name: _____

DOB: (mm/dd/yyyy): _____

Home Address: _____

Phone Number: _____ Email Address: _____

Medical Insurance: (Name/Group#): _____

Insurance Member #: _____

Emergency Contact: (Name/Relationship): _____

Phone Number: _____ Email: _____

Diagnosis	Diagnosis Date	Health Care Provider	Treatment

Prescription Medications	Strength	Dose	Frequency
OTC Medications	Strength	Dose	Frequency

ALLERGIES

Medication (reaction)	Food	Environment

Date Updated _____

Note: Place one copy in your luggage and another on your person with your important documents (passport, etc.)