## 2 API USA • Personal Medical Information

Trip Dates ______________ to ______________

Name ________________________________________ Age ____ Gender ___ M ___ F Height ______ ins Weight ______ lbs

Address ____________________________________________ City ________________________ State ____ Zip _______________

Ph 1 _______________________ Ph 2 ________________________ Email ______________________________________________

**Emergency Contacts (2 Names) Do not use the names of people who will be traveling with you on this trip.**

(1) Name __________________________________ Relationship __________________ City/State ___________________________

Ph 1 _______________________ Ph 2 ________________________ Email ______________________________________________

(2) Name __________________________________ Relationship __________________ City/State ___________________________

Ph 1 _______________________ Ph 2 ________________________ Email ______________________________________________

**Health History**

Describe Your Current Health Status ___ Excellent ___ Very Good ___ Good ___ Poor ___ Very Poor

Blood type (if validated) ________ Do you have existing or chronic health issues? ___ Yes ___ No, if "Yes" please list/explain below

____________________________________________________________________________________________________________

U.S. Doctor (contact in case of emergency) ___________________________________________ Phone _______________________

Are the vaccinations/medications for this trip suggested by the CDC, travel clinic or your personal doctor up-to-date? ___ Yes ___ No

If "No" please explain ______________________________________________________________________________________

Do you have a significant allergic reaction to any medications or substances? ___ Yes ___ No, if "Yes" please list & explain below

____________________________________________________________________________________________________________

List all prescribed or OTC (over the counter) medications you will take on this trip and their daily, weekly or monthly dosages.

____________________________________________________________________________________________________________

List any health problems, including musculoskeletal & dietary, that may require special consideration during this trip.

____________________________________________________________________________________________________________

Do you currently smoke? ___ Yes ___ No, Can you walk a mile carrying a daypack with a 30 lb load? ___ Yes ___ No

Do you wear ___ glasses ___ contacts? Do you have a hearing/speech problem making communication difficult? ___ Yes ___ No

List any sleeping conditions you have that may disturb others or put you at risk (snoring, insomnia, sleep apnea, RLS, CPAP, etc.).

____________________________________________________________________________________________________________

Use the box below to include ANY OTHER information you feel may be pertinent to your health & safety or others during this trip.

**I certify ALL the above information is correct to the best of my knowledge.**

_________________________________ _________________________________ ___________________

Signature | Printed Legal Name | Date

**Return As Soon As Possible to: API USA, P.O. Box 235047, Encinitas, CA 92023-5047**