



Date: \_\_\_\_\_

Dear Senior Traveler:

If a medical problem occurs while on a trip, it is important for us to have the following information about you. Please fill out the form below and return it to: Aging & Disability Resource Center, 315 West Oak Street, Suite A, Sparta, WI 54656.

NAME \_\_\_\_\_ PHONE NO. \_\_\_\_\_

Birthdate \_\_\_\_\_ CELL NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

Please tell us of any medical condition(s) we should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone No. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

Clinic \_\_\_\_\_ Doctor \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

For a medical emergency, the local emergency response system will be called.