

**Dallas Genealogical Society
Salt Lake City Research Trip
October 10- 17, 2010**

SLC Trip Medical Forms

Every participant in the DGS Salt Lake City trip must return the following two forms to DGS before they will be allowed to join the group. Part I is the "Emergency Medical Authorization" form which must be signed and dated. Part II is a "Medical Information Form" which should be filled out as completely as possible. Place Part II and photocopies of your insurance card (back and front) and your driver's licence in a sealed envelope with your name on the front. It will only be opened in case of a medical emergency and will otherwise be returned to you unopened at the end of the trip. **Put the sealed envelope along with the signed Emergency Medical Form into another envelope and mail it to:**

SLC Trip
Dallas Genealogical Society
PO Box 12446
Dallas, Texas 75225-0446

I. EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize the designated representatives of the Dallas Genealogical Society Salt Lake City Research Trip to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization and I will not hold the Dallas Genealogical Society or its designated representatives responsible for any consequences of this medical treatment. The authorization is effective for the length of the Salt Lake City Research Trip, November 1-8, 2009. I have read the above authorization, and confirm that the information, contained therein is true and accurate.

Signature of Participant

Date

Optional: You may write on the back of this paper any food allergies or medical conditions you would like to have known to the group leaders.

II. MEDICAL INFORMATION (please type or print legibly; use back if necessary for more space)

a. Participant's Name _____

Date of Birth _____

Address _____

Telephone Number (Home) _____ Cell) _____

b. Name of Nearest Relative _____

Address _____

Telephone Number: (Home) _____ (Cell) _____

c. Physician's Name _____

Address _____

Telephone Number (Day) _____ (Night) _____

d. Dentist's Name _____

Address _____

Telephone Number (Day) _____ (Night) _____

e. Health Insurance Company Name _____

Policy Number _____ Telephone Number _____

f. Allergies _____

g. Current Medications _____

h. Special Health Needs _____

Do not forget to put photocopies of your insurance card (front and back) and your driver's licence with this Medical Information Form in a sealed envelope with your name written on the front.