OFF THE BEATEN PATH, INC.
Gold Card Club & Platinum Elite

PAUL GIFFORD, PRESIDENT

800.221.3155
507.334.2362
507.333.2473 FAX

P.O. BOX 853
FARIBAULT, MN 55021
girl10500@yahoo.com

OFFICE HOURS
10 am-5 pm MON-FRI
www.otbp.info

EMERGENCY MEDICAL CARE AUTHORIZATION

I,_____, herein give Off the Beaten Path, Inc. permission to
(Parent/Guardian/Self-Guardian)
procure emergency medical care, and to sign necessary medical release forms for

_____ while on vacation.
(Consumer)

This permission is given with the understanding that the attending physician, in his/her professional opinion, deems emergency medical attention necessary. Off the Beaten Path, Inc. will make an effort to contact the parent or guardian prior to assuming the responsibility for signing a release for emergency treatment. Only in the event that the parent or guardian cannot be contacted, or cannot come to the hospital themselves to sign, is this authorization to be used.

Will you be insuring your vacation for loss due to illness and/or other covered events?**___yes___no**
Consumer's right to a refund is limited. Please see reservation policy. Call for insurance information.

I have read, understood, and agreed to the Reservation Policies and Contract (blue form).

Signed_____
(Parent/Guardian/Self-Guardian)

Medical/Health/Identifying Information

NAME (as it appears on state issued ID or passport) _____

ADDRESS_____

CITY_____STATE_____ZIP_____PHONE_____

HEIGHT_____WEIGHT_____HAIR COLOR_____EYE COLOR_____

D.O.B_____AGE_____SEX_____

DISTINGUISHING FEATURES_____

PHYSICIAN'S NAME_____PHONE_____

_____SOC.SEC.#_____
(Hospitalization Ins. Name and #, or Medical Assistance #)

_____(____)_____(____)_____
***24-Hour* Contact Person's Name** Cell Number Phone Number

2018

THIS FORM MUST BE COMPLETED IN FULL

PRIMARY DISABILITY_____SECONDARY DISABILITY _____

DATE OF TETANUS SHOT_____DATE OF FLU SHOT (required for OTBP travel Aug.-April) _____

ALLERGIES (FOOD, MEDICATION OR OTHER) _____

EPILEPSY/TYPE_____FREQUENCY_____PRECIPITATING CAUSES_____

ARE LIMITED ALCOHOLIC BEVERAGES PERMITTED? _____

MEDICATIONS ***Please see insert for requested medication packaging information*

**Please list all medications presently being taken, including PRNs. Attach a separate sheet if necessary.

NAME OF MEDICATION DOSAGE TIME ADMINISTERED

_____

_____

_____

_____

_____

DOES CONSUMER SELF-ADMINISTER? **YES** **NO**

IF CONSUMER DOES NOT COMPLETELY SELF-ADMINISTER OR NEEDS VERBAL REMINDERS, PLEASE CIRCLE NO.

LIST ADDITIONAL MEDICAL OR PHYSICAL LIMITATIONS INCLUDING ANY COMMUNICABLE DISEASE

_____

_____

SOCIAL/BEHAVIORAL INFORMATION

**Please indicate level of supervision needed by using independent, verbal assist, or physical assist.

TOILETING_____MONEY MANAGEMENT_____

DRESSING_____SHOWERING_____

EATING_____SURVIVAL SKILLS GOOD LIMITED MINIMAL

**Please check all that apply

_____PHYSICAL AGGRESSION

_____USES WALKER/CANE

_____HISTORY OF STEALING

_____INAPPROPRIATE TOUCH

_____REQUIRES WHEELCHAIR FOR LONG DISTANCES

_____FABRICATES STORIES

_____VERBALLY AGGRESSIVE

_____WETS THE BED

_____WANDERS

_____INTERACTS INAPPROPRIATELY WITH OTHERS

PLEASE DESCRIBE ANY POSSIBLE BEHAVIOR PROBLEMS AND HOW THEY ARE BEST HANDLED.

_____

_____

_____

(Based on your comments, we may request additional information.)

HAS CONSUMER EVER BEEN DENIED ACCESS TO OTHER VACATION PROVIDERS? YES NO

THIS FORM MUST BE COMPLETED IN FULL