PROGRESSIVE TRAVEL
SPECIALTY TOURS

RESERVATION FORM

TOUR NAME: ______________________________**TOUR DATE(S):** ________________

TRAVELER'S NAME:____

Traveler's phone: (_____)________________Cell Phone: (______)______________

Traveler's address: ______________________City___________St_____Zip______

****

Tour Cost: $_____________ Optional Travel Insurance $_______ TOTAL $_________

****

Billing Information:

Billing address: __________________________City__________St_____Zip______

Contact agency/person: ____

Phone: (_____)____________________Cell Phone: (______)__________________

****

Traveler Identification:

Age: _________ Date of Birth: __________ Eyes:_____________

Height: _______ Weight: ______________ Hair:______________

*****If you are a first time traveler with Progressive Travel please include a photo.***

****

Traveler's Name As Shown On Photo I.D. _________________________
(First, middle initial, last name)

****

Multiple day trips:

Name of roommate if any that you are traveling with: ______________________________

****

TOUR CONTRACT

Emergency Medical Care Authorization

By signing this contract, I give permission for my assigned chaperone to proceed with emergency medical care and to sign necessary medical release forms. This permission is given with the understanding that the attending physician deems emergency medical attention is necessary. Progressive Travel, Inc. or a Chaperone will make every effort to reach the guardian prior to assuming the responsibility for signing a release for emergency medical treatment. This authorization will be used only in the event that the guardian cannot be reached.

Tour Name / Date: ____

By signing, I acknowledge that I understand and agree to the terms of the Progressive Travel, Inc. Special Tour Contract.

____ _____________________

Traveler (Signature) Date

____ _____________________

Witness (acknowledging the traveler has no guardian) Date

____ _____________________

Guardian Signature (Required if Appointed) Date

(The following section must be completed)

Guardian Name & Address: ____

____

____

Guardian Phone: (_______)______________________________

PHOTO AUTHORIZATION RELEASE

☐ Yes, please feel free to use photos of this traveler taken on our tours for future Progressive Travel publications.

☐ No, I do not wish photo's of this traveler to be used for any future publications.

_________________________________ _______________________

Signature Date

Participant Information Form

Name: ____ Male________ Female________

Phone:____

Home Address:____

____

Emergency Contact Person: ____

Address: ____

____

Day Phone: (____)_________________________ Night Phone: (____)______________________

Physician's Name: _________________________ Phone: (____)__________________________

Medical Assistance Number: ____

Please list any special considerations that Progressive Travel, Inc., Special Tours should be aware of: (assistance needed, mobility needed, health needs, dietary restrictions, etc.)

____

____

____

____

____

Medication: (Type/Dosage/Time)

Type	Dosage	Time

Cont. on back if needed

Please complete the following information:

It is mandatory that this information is as accurate and up to date as possible for the traveler for which this reservation is for.

	Yes	No
1. Tumors	☐	☐
2. Strokes	☐	☐
3. Seizures, Fainting Spells	☐	☐
4. Severe or Frequent Headaches	☐	☐
5. Thyroid Disease	☐	☐
6. Vision Problems	☐	☐
7. Contact Lenses	☐	☐
8. High Blood Pressure	☐	☐
9. Heart Problems/murmurs, etc.	☐	☐
10. Chest Pains/Difficulty Breathing	☐	☐
11. Asthma/Chronic Cough	☐	☐
12. Stomach/intestinal problems	☐	☐
13. Diabetes (on insulin)	☐	☐
14. Bladder/Kidney Problems	☐	☐
15. Cancer	☐	☐
16. Gout/Arthritis/Joint Pain	☐	☐
17. Bone/Muscular Problems	☐	☐
18. Allergies	☐	☐
19. Skin Diseases	☐	☐
20. Back Problems	☐	☐
21. Hearing Loss/Ear Problems	☐	☐
22. Is traveler a smoker?	☐	☐
23. Is traveler a first time flyer?	☐	☐
24. Does traveler know how to swim?	☐	☐
25. Does traveler have any fears?	☐	☐

	Yes	No
26. Can traveler be given over the counter drugs such as Advil, Tylenol, etc.	☐	☐
27. Does the traveler use a walker, cane or wheelchair?	☐	☐
28. Does the traveler have problems walking long distances?	☐	☐
29. Is traveler able to handle his/her own money?	☐	☐
30. Does traveler have any bladder/bowel control concerns?	☐	☐
31. Is traveler able to take care of their bathroom needs on their own?	☐	☐

****Any questions marked "yes" that need an explanation, please do so in space above or on the back of this page!**

I, ________________________ have filled this form out to the best of my knowledge. My relationship to this traveler is ________________________.

(Case Manager, Guardian, etc.)

____
Signature

____
Date

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