

# SPECIAL CARE TRAVEL BOOKING FORM

Tour Name  
Tour Dates  
Name of Traveler Gender DOB  
Street Address Suburb  
Post Code State Home Phone Mobile  
24 Hour Emergency Contact Person Phone Mobile  
Medicare No Pension No Companion Card No  
Passport No if going overseas or cruising Expiry Date

[Travel Insurance is mandatory for Cruises & Overseas Travel please provide copy of certificate](#)

Any Known Allergies or Phobias

Medical Condition/Description of Disability

Doctors Name Phone Fax  
Doctors Address or Email  
Care Facility or Organisation Name Manager  
Office Address Suburb State Postcode  
Email Phone Mobile  
Person completing this booking form, Carer, Parent, Legal Guardian, Decision Maker  
Name Relationship  
Address Suburb State Postcode  
Phone Mobile Fax/Email

## MEDICATION

Special Care Travel staff are certified to assist with administering medication and will assist you to take your medication if required, as per instructions provided to us. Medication must be in Webster packs with 3 days extra in case of unexpected circumstances. All other Medications must be clearly labeled with clear administration instructions.

Please attach a photograph to Webster pack. Please complete consent below.

I give consent for Special Care Travel to assist in administering Medication to

Name of Medication	Dosage	Times	Path
:			
:			
:			
:			
:			
:			
:			
:			
:			

NDIS Details Please answer yes to one of the following.

Agency Managed	Plan Managed	Self-Managed	Co Ordinator's Name
Phone	Email		
Organisation Name		Address	
Phone	Email		
Participants NDIS No.	Plan Start Date	Plan End Date	