

GENERAL PACKING LIST

CLOTHING (per person)	
<input type="checkbox"/> Day #1 : _____ <input type="checkbox"/> Day #2: _____ <input type="checkbox"/> Day #3: _____ <input type="checkbox"/> Day #4: _____	<input type="checkbox"/> Night # 1: _____ <input type="checkbox"/> Night #2: _____ <input type="checkbox"/> Night #3: _____ <input type="checkbox"/> Night #4: _____
<input type="checkbox"/> Workout/Active Wear <input type="checkbox"/> Swim Suit	<input type="checkbox"/> Pajamas _____ pair <input type="checkbox"/> Lounge Wear
<input type="checkbox"/> Socks _____ pair <input type="checkbox"/> Stockings _____ pair	<input type="checkbox"/> Underwear _____ pair <input type="checkbox"/> Bras/Undershirts _____ pair
<input type="checkbox"/> Shoes #1: <input type="checkbox"/> Shoes #2: <input type="checkbox"/> Shoes #3: <input type="checkbox"/> Shoes #4:	<input type="checkbox"/> Coat/Jacket <input type="checkbox"/> Outer Ware <input type="checkbox"/> Jewelry <input type="checkbox"/> Belts/Accessories
TOILETRIES/COSMETICS	
<input type="checkbox"/> Shower Supplies <input type="checkbox"/> Shampoo/Conditioner/Soap/Gel <input type="checkbox"/> Razor/Shaving Lotion <input type="checkbox"/> Cosmetics <input type="checkbox"/> Moisturizer/Foundation <input type="checkbox"/> Blusher/Bronzer/Brushes/Powders <input type="checkbox"/> Eye Shadows/Pencils/Mascara <input type="checkbox"/> Lip Pencils/Lip Sticks <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> Medications <input type="checkbox"/> Pain Reliever <input type="checkbox"/> Vitamins <input type="checkbox"/> Prescriptions	<input type="checkbox"/> Toiletries <input type="checkbox"/> Eyeglasses/Contacts/Cases/Solution <input type="checkbox"/> Deodorant/Body Lotion <input type="checkbox"/> Toothpaste/Toothbrush <input type="checkbox"/> Cotton Squares/Q-tips <input type="checkbox"/> Hair Care <input type="checkbox"/> Brush/Comb/Clips/Accessories <input type="checkbox"/> Sprays/Gels <input type="checkbox"/> Hair Dryer/Curling Iron/Flat Iron <input type="checkbox"/> _____ <input type="checkbox"/> Children's Medication <input type="checkbox"/> Pain Reliver <input type="checkbox"/> Antihistamines/Decongestants <input type="checkbox"/> Bug Spray/Sunscreen <input type="checkbox"/> Thermometer
ELECTRONICS	
<input type="checkbox"/> Laptop/Adaptor	<input type="checkbox"/> Camera/Batteries/USB Cord
<input type="checkbox"/> Cell Phone/Adaptor/Car Charger	<input type="checkbox"/> Electronic Games/Batteries/Cartridges
<input type="checkbox"/> PDA/Base	<input type="checkbox"/> iPod/Kindle/etc.