PARTICIPANT INFORMATION FORM

NOTE: To become a participant of any of our programs, there is some information about you that we must have. Please complete this form and forward to us at your earliest convenience.

GENERAL INFORMATION

Program Name: _____

Departure Date: _____

PASSPORT OR RESIDENCE INFORMATION (US)

Your Name (As it appears in your passport) _____

Your Date of Birth: _____ (Month/ Day /Year)

Home Address: _____

ZIP Code_____ Email address: _____

Cell No._____ Mother's maiden name_____

Gender __ Male __ Female Citizenship: _____

Passport No._____

Passport Date of Issuance_____ Passport Expiration Date; _____

Passport County of Issue_____ Passport Issue Authority: _____

CUBAN PASSPORT INFORMATION (IF APPLICABLE)

Your Name (As it appears in your passport) _____

Passport No._____ Passport Expiration Date _____

MEDICAL INFORMATION:

Do you have any medical conditions such as: Allergies ☐ Injuries ☐ Diabetes ☐ Emphysema ☐

Heart Condition ☐ Seizures ☐ Recent Surgeries ☐

Or any other that would be important to know in case of emergencies? Please describe

_____

Do you have any impairments or restrictions such as impaired mobility, hearing, vision, etc. that may prevent you from participating fully in any of our programs, or may require special rooming or equipment as well as assistance for you to participate in any or our programs? Please describe:

_____

Do you use or travel with any mobility assistance or medical equipment? ☐ Yes ☐ No

☐ Cane ☐ Walker ☐ Wheelchair ☐ Scooter ☐ Oxygen ☐ CPAP ☐ Service Animal ☐ Other

Do you regularly use prescription medication? ☐ Yes ☐ No

If yes, please list and indicate reason for taking these medications. (Attach another page if more space is required).

_____

Any restrictive food allergies or intolerances? ☐ Yes ☐ No

(Participants are solely responsible for making sure they do not consume foods they are allergic to)

Primary Care Physician Name: _____ Tel No._____

24 hr. Emergency Number for your Physician: _____

Do you have medical, accident or illness insurance other than Medicare? ☐ Yes ☐ No

If yes, please specify;_____

Any other health information you would like us to know?

_____

EMERGENCY CONTACT

(Please list someone other than your traveling companion)

Name of Emergency Contact: _____

Relationship _____

Home Tel. No._____ Cell Phone No. _____

Other No._____

City and State_____ Country_____

LODGIND PREFERENCES

(We can't guarantee any lodging preference, but we will try our best)

Room configuration: ☐ One bed ☐ Two beds

Double room ☐ Single room ☐

PLEASE NOTE:

This program does not provide for transfers to and from the airport prior to meeting the group at the designated time and place for departure. You are solely responsible for these arrangements. However, it is important that we know: Where will you be meeting the group for departure?

_____

Will you be celebrating a birthday, an anniversary or any special occasion on this program?

☐ Yes ☐ No. Please specify:_____

THIS FORM MUST BE COMPLETED AND MAILED TO US AT LEAST 6 WEEKS PRIOR TO THE BEGINNING OF THE PROGRAM.

☐ I have read and accepted the terms and conditions

SIGNED:_____

DATE:_____