

Participant Contact & Medical Form

(All information is private and will only be used by Camera Treks personnel for your safety and the safe conduct of the Tour)

Location or Name of Tour

Dates

Participant Full Name

First (Given):

Middle:

Last (Family Name):

Preferred Name:

Address

Street & Number:

City:

State/Province:

Country:

Zip Code:

Mobile Telephone:

Home Telephone:

Email:

EMERGENCY CONTACT

First (Given) Name:

Middle:

Last (Family Name):

Relationship to You:

Mobile Telephone:

Home Telephone:

Work Telephone:

Email:

MEDICAL INFORMATION

Personal Physician:

Telephone:

Medical Insurance Carrier:

Policy Number:

Contact:

Travel Insurer:

Policy #:

Med-Evac Insurer:

Policy #:

Covid-19 Vaccination Yes No *If 'Yes' attach photocopy or jpeg of both sides of your CDC official vaccination certificate.*

Do you have *any* medical condition(s) important for us to know about that might be exacerbated by this trip?

No. I have no allergies (food, medicines, environmental, etc.) to declare to Camera Treks.

Yes. I have the following allergies or medical conditions that might be affected by food/activities/environmental that Camera Treks should know about:

Food/Drink

*

*

Environmental (such as allergies to wool or feathers, for example)

*

*

Other issues

*

*

Do you have *any* medical condition(s) important for us to know about that might be exacerbated by this trip?

Are there *any* other things Camera Treks should know about?

[Use the other side of this form if you need to.]

Signature

Date

Print Name

Date