EDUCATION ACROSS BORDERS
IMMERSION PROGRAM
MEDICAL INFORMATION FORM

Program Participant Name:_____

Education Across Borders does not provide any medical assistance or support on our programs, and the laws of the United States, and of individual U.S. states of the United States and of their local jurisdictions, do not apply to our programs because our programs take place in Latin America. However, if you were to have a medical emergency on our program and were unable to communicate personally, we want to have available relevant information regarding any medical conditions or limitations that you may have. . This is a three-part form in which we require medical information from you, the name and phone number of your current physician, and the name of persons to contact in case of an emergency. Although we do not have a duty to provide medical assistance on this program, we also need you to inform us of any health concerns that may require accommodation so that we can determine whether to make any accommodation.

If we have any reason to believe that you have a condition that will endanger your health and safety or the health and safety of others, or that would require us to change the nature of the program experience that we provide, we reserve the right, prior to and during the program, to ask for a doctor's written approval verifying that you are physically and mentally able to participate in the program without endangering your health or safety or the health or safety of others. A copy of this information will be given to your program director, who will keep it confidential unless there is a medical emergency, in which case your director may provide this information to an attending care provider or emergency responder and/or use it to contact the people you list in Part 3 below.

IMPORTANT: Each program participant **must complete, sign, and return this form prior to participating in this program.**

PLEASE PRINT THIS IMPORTANT INFORMATION CLEARLY. Please attach additional pages if necessary.

Part 1: MEDICAL INFORMATION

Please list any past or present physical or mental conditions that will or may affect, limit or inhibit your ability to participate in the EAB immersion program (such as, but not limited to: mobility limitations, restrictions or limitations on physical exertion, impairments of any of your senses, cognitive difficulties, heart conditions, dietary restrictions, allergies, arthritis, physical or mental illnesses, chronic or acute diseases, disabilities, substance addiction or abuse, etc.) and any medications you are currently taking to treat these conditions or for any other reason, and the daily dosage required for each medication. Absolute transparency is critical for your health.

ALLERGIES:_____

DIETARY RESTRICTIONS:_____

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PHYSICAL OR MENTAL CONDITIONS_____

_____

_____

MEDICINES	**DOSAGE PER DAY**

DOCTOR'S NAME AND TELEPHONE NUMBER

_____

Part 2: INSURANCE INFORMATION

Medical Insurance Company:_____
Plan or Policy: _____
Group #: _____
Primary Insured:_____

Travel Insurance Company: _____
Plan or Policy:_____
Name of Insured:_____

Part 3: EMERGENCY CONTACTS

Please list the names of persons you wish us to contact in case of an emergency during your program. (You must list AT LEAST one; additional contacts are encouraged in case we cannot reach the first.) We ask for their telephone numbers, including area code, and an email address. The email address will only be used to provide important information regarding your program in an expedient manner. The email address will not be shared with anyone outside EAB.

Name:_____ Relationship:_____
Evening Phone:_____ Cell Phone:_____
Email: _____

Name:_____ Relationship:_____
Evening Phone:_____ Cell Phone:_____
Email: _____