



# STUDENT TRAVEL REGISTRATION FORM

## Participant Information

Trip details: \_\_\_\_\_  
Name Dates

Name: \_\_\_\_\_  
First Name (as it appears on passport) Middle Name Last Name

Name of School/College: \_\_\_\_\_ Teacher: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
Cell WhatsApp

Home mailing address: \_\_\_\_\_  
Street City State Zip Country

Citizenship/Country Issuing Passport: \_\_\_\_\_ Passport Number: \_\_\_\_\_

Passport Exp. Date: \_\_\_\_\_ Country of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female  
mm/dd/yyyy mm/dd/yyyy

## Insurance

Check here to indicate you understand that emergency health and evacuation/cancellation insurance is NOT included in the program fee.

# HEALTH FORM

*This information will be treated confidentially, and individual items will be shared on a need-to know basis essential for meeting individual participant needs. In the event of an emergency, this information will be provided to appropriate medical providers.*

## Parent/Guardian

Parent/Guardian I: \_\_\_\_\_  
Name Phone Number(s) E-mail

Parent/Guardian II: \_\_\_\_\_  
Name Phone Number(s) E-mail

## Accessibility Information

Travelers are informed that public accommodations, historic sites, and walking tours outside the US are typically not optimally accessible to those who have mobility impairments. Based on planned destinations participants may be expected to climb up to 3 flights of stairs and walk up to 3 miles each day. Should a participant require personal support staff to fully participate in the program, Colibri requires travelers to provide such supports (including support staff salary, travel, and program costs) at their own expense. **Failure to disclose on this form any condition or need that would require reasonable accommodation may result in the inability of Colibri and its representatives and agents to provide accommodations, and further, are informed that should they fail to disclose such information, they may be returned home at their sole expense and without a refund.**

Please provide explanation of accessibility needs: \_\_\_\_\_  
\_\_\_\_\_

## Dietary Requests

We will attempt to accommodate dietary needs but cannot guarantee certain meal requests. Please understand that we cannot control the contents of all food products during travel. Participants with dietary allergies are ultimately responsible for inspecting all food for ingredients related to the allergy.

Describe any dietary requests: \_\_\_\_\_  
\_\_\_\_\_

## Allergies please list

Allergy	Reaction	Required Medication	Life Threatening?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

For allergic emergencies, I will be carrying auto-injectable epinephrine (EpiPen)  Yes  No

## Medications Please describe any medications/treatments you will be using while on the delegation

Medication	Reason	Medication	Reason

## Other Health Conditions

Please list any other issues or conditions, such as but not limited to, acute medical issues, seizure disorders, diabetes, anxiety or other

\_\_\_\_\_

This form is completed only with the copy of your passport (bio page). Passport must be valid at least 6 months from the trip return date.

