COLIBRI TRAVEL REGISTRATION FORM

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Participant information

Name:_____
First Name (as it appears on passport) Last Name Trip Dates

Occupation:_____
Title Employer

Email:_____ Phone:_____
Cell Home

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

Emergency Contact:_____
Name Phone Number(s) Email

Your first language:_____ Other languages you speak:_____

Do you have any specific interests in regard to country (countries) listed on this trip?_____

_____

Rooming information

☐ I prefer a double room

☐ I will be rooming with_____ Provide ☐ Two twin beds or ☐ One double bed

☐ Please try to match me with a roommate (two beds). I agree that if no roommate is available, I will pay for a single room

☐ I prefer a single room

Airport transfer

Do you need airport transfer service? ☐ Yes ☐ No, I will arrange on my own

Insurance

Emergency health and evacuation/cancellation insurance is NOT included in the program fee.

Other Information

How did you hear about us?_____

Promo Code (if you have): _____

Colibri reserves the right to accept or decline any person as a participant. Colibri does not discriminate based on race national origin, age, disability, gender, sexual orientation, or any other category protected by applicable law.

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.

Participant Information

Name:_____ Date of Birth:_____ ☐ Male ☐ Female
First Name Preferred Name Last Name mm/dd/yyyy

Emergency Contact:_____
Name Phone Number(s)

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.**

Check all that apply:

- ☐ Use a wheelchair, scooter, walker, crutches, cane or other mobility aid.
- ☐ Have sensory or other mobility issue relevant to airline travel, sleeping room, walking tours, or motor coach use.
- ☐ Require large print materials (this request will be provided to seminar planners).
- ☐ Will be traveling with personal support staff, interpreter, or service animal.
- ☐ Other accommodations needed (describe below).

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?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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

All participants are responsible for their recurring medical treatments without supervision. All medications, injections, and other treatments must be monitored and administered by the participants themselves. Those with dietary allergies are ultimately responsible for inspecting all food for ingredients related to the allergy.

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Physician Contact Information

Physician's Name:_____ Physician's Phone:_____

Office Phone:_____ Email:_____

Insurance Information

Insurance Provider:_____ Group Number:_____

Name of Covered Member:_____ Insurance Phone Number:_____

Medical Treatment, Information Sharing, and Disclosure Waiver

In the unlikely event that you need professional medical treatment during the program, signing the release below allows for your prompt care, and the information on this form to be shared with health care providers and your medical information to be shared with Colibri Group.

I_____, do hereby give authorization to Colibri Group and its representatives and agents to seek and provide medical service to me when deemed appropriate by its staff.

I authorize and give full consent to Colibri staff to enable prompt care and attention in case of illness or accident while participating in this program. I authorize Colibri to incur necessary expenses and agree to pay the same if in excess of the amount provided by any applicable insurance policy.

I also give authorization to any medical facility and medical staff to share my personal medical information related to a current medial situation with any Colibri staff, representatives, and agents.

I further acknowledge and agree that all of the preceding requested information is necessary to ensure safe participation in the program and its activities.

I understand that 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, should I fail to disclose such information, I may be returned home at my sole expense and without a refund.

Signature:_____ Date:_____

Print Name:_____

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.

All participants are responsible for their recurring medical treatments without supervision. All medications, injections, and other treatments must be monitored and administered by the participant themselves. Those with dietary allergies are ultimately responsible for inspecting all food for ingredients related to the allergy.