

# GATE REGISTRATION FORM

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Name \_\_\_\_\_  
(as appears on passport)

Address \_\_\_\_\_

City \_\_\_\_\_ State/Prov \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

E-mail Address \_\_\_\_\_

Preferred country/dates of program \_\_\_\_\_

Gender **F M**

Will you be traveling with a spouse/ family member/ friend? \_\_\_\_\_

How did you find out about the GATE program? \_\_\_\_\_

Passport information: Country of Citizenship \_\_\_\_\_

Passport Number \_\_\_\_\_ Date of Issuance \_\_\_\_\_

Expiration Date \_\_\_\_\_ Birthplace \_\_\_\_\_

Spanish Language Ability (for Mexico, Guatemala, El Salvador programs)

\_\_\_ none \_\_\_ beginning \_\_\_ conversational \_\_\_ fluent  
(for other trips, name language(s) and indicate fluency)

**Your answers to the following questions are helpful to the GATE staff:**

Religious affiliation/denomination: \_\_\_\_\_

Other groups/organizations in which you participate, particularly ones that may relate to travel in the region you will be going

\_\_\_\_\_  
\_\_\_\_\_

Have you been to this region previously? \_\_\_ no \_\_\_ yes If so, please list years and purpose of previous trips/experiences:

\_\_\_\_\_

Have you visited any other Third-World countries? \_\_\_\_\_

What are your objectives/hopes for this experience?

\_\_\_\_\_

\_\_\_\_\_

Please write a short profile. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICAL INFORMATION

The following information is confidential to the GATE staff. We ask you to assess your health in light of the demands of travel outside of Canada/USA.

1. Name \_\_\_\_\_ Age \_\_\_\_\_  
Blood Type \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Do you suffer from any of the following conditions?

\_\_\_ epilepsy                      \_\_\_ emphysema                      \_\_\_ allergies (also to medicine?)  
\_\_\_ high blood pressure                      \_\_\_ heart condition                      \_\_\_ back problems or injuries  
\_\_\_ diabetes                      \_\_\_ shortness of breath                      \_\_\_ cancer  
\_\_\_ any other concerns? Please check items.

Do you have a history of:

\_\_\_ alcoholism? \_\_\_ eating disorders? \_\_\_ substance abuse or chemical dependencies?

How might any of these conditions affect you during international travel?

Do you snore? \_\_\_ no \_\_\_ yes                      Do you smoke? \_\_\_ no \_\_\_ yes

3. Are you currently or have you been under a doctor's care during the past 6 months?

\_\_\_ no \_\_\_ yes If yes, what condition(s) are being treated?

4. Have you ever been treated by a psychiatrist, psychoanalyst or therapist for any mental, emotional or nervous disorders? \_\_\_ no \_\_\_ yes If yes, how would this affect travel in a foreign country?

5. Immersion experiences are intense, both physically and emotionally. Have you any traumas or life changes in the past 6 months?

6. Do you carry any medication (other than for diarrhea or upset stomach)? If so, please specify names, conditions which they treat and possible side effects.

7. Do you have any food allergies? \_\_\_ no \_\_\_ yes If yes, what are they?

8. Would you prefer a vegetarian menu? \_\_\_ no \_\_\_ yes

If yes, do you eat **dairy**? \_\_\_ no \_\_\_ yes **Fish/seafood**? \_\_\_ no \_\_\_ yes **Chicken**? \_\_\_ no \_\_\_ yes

**It is imperative that you let us know of any food allergies or food needs on this form. If we do not know your needs early there is no way we can provide for them.**

9. Medical Insurance: In case of a medical emergency, does your policy cover expenses outside of the USA/ Canada? \_\_\_ no \_\_\_ yes

Please name your insurance carrier and policy number:

10. Will you assume any and all possible medical costs incurred during the program?

11. Any other comments on your health?

In case of illness or emergency, please notify:

Name \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State/Prov. \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
(day) (evening)

\_\_\_\_\_  
Name of applicant (Please print)

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

### PERMISSION FORM FOR EMERGENCY MEDICAL TREATMENT

On rare occasions an emergency requiring hospital treatment may develop during a GATE program. In most cases, administration of an anesthetic, treatment of an injury, or operation on an individual cannot be done without consent of the patient. To avoid a potentially dangerous delay in an emergency and/or if you are unconscious or otherwise unable to give your consent, we request that you sign the following permission to ensure necessary medical treatment.

I hereby grant permission to the GATE staff to authorize the administration of such antibiotics, immunizations, anesthesia and other medications and to hospitalize and provide such treatment for myself that they consider appropriate based on the advice they have received.

I hereby further waive and release any claim I may have against the GATE Staff/Program, its employees, sponsors, and representatives in regard to these decisions in the administration of emergency medical treatment as described herein.

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Date

## GATE RELEASE OF LIABILITY AGREEMENT

(Please read carefully before signing)

1. I, \_\_\_\_\_, have applied and intend to participate in a GATE program.
2. I have voluntarily registered for this program outside of the USA/Canada. I have paid a registration fee to the GATE office in La Crosse, Wisconsin.
3. I understand and I am aware that during the program in which I participate, certain dangers and/or risks may arise. I expressly voluntarily assume all risk of injury, illness, death and property damage or loss that may result from participation in the GATE program.
4. I also agree to abide by all applicable rules and regulations of the GATE program while participating in the program. I understand that noncompliance may result in expulsion from the program and forfeiture of program fees. I agree that if I violate any applicable law, rule, regulation, instruction at any time during the program I may be sent home immediately at my own expense. I further agree that the GATE staff may send me home at any time during the program if they determine that my continued participation the program will adversely affect my health, safety or welfare or the health, safety and welfare or enjoyment of other GATE program participants.

**I have carefully read this agreement and release form and fully understand its contents. I sign if of my own free will.**

\_\_\_\_\_  
Participant's name and date of birth (please print)

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Date

**Important: If the participant is a minor, a parent or legal guardian must sign.**

I am the participant's parent or legal guardian. I am signing this agreement and release form on my own behalf and on behalf of the participant and her/his heirs and assigns.

**I have carefully read this agreement and release form and fully understand its contents. I sign if of my own free will.**

\_\_\_\_\_  
Parent or legal guardian's name (please print)

\_\_\_\_\_  
Parent or legal guardian's signature

\_\_\_\_\_  
Date

Please return this completed form to : GATE Office, 912 Market St., La Crosse, WI 54601-8800 USA (**Fax:** 608.782.6301 or **Tel:** 608.791.5283)