GATE REGISTRATION FORM

Name _____
(as it 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 where 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

Car/Van travel is difficult for me: ____ no ____ yes Plane Travel is problematic for me: ____ 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 had 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.

Please answer ALL food questions by circling the YES or circling the NO, whether you are vegetarian or not.

7.) Do you have any food allergies? YES NO
A.) If yes, what are they?

8.) Do you eat DAIRY? YES NO

9.) Do you eat FISH/SEAFOOD? YES NO

10.) Do you eat CHICKEN? YES NO

11.) Would you prefer a vegetarian menu? YES NO

It is <u>IMPERATIVE</u> that you let us know of any *food allergies* or *food needs* on this form. If we do not know your needs prior to your arrival there is no way we can provide for them.

12. **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:

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

14. Any other comments on your health?

15. Vaccination status: _____ J & J _____ Pfizer (2) _____ Moderna (2) _____ booster _____ Not Vaccinated
Boosters - Name of boosters given: _____

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 surgery 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 medical 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. I release GATE, its director and personnel, FSPA, its officers, employees and agents of any liability and claim for damages or compensation for injuries, illnesses, death or property losses related to or arising out of performance of this Agreement.

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 it 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 it 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 and the $100.00 registration fee to:
GATE Office, 912 Market St., La Crosse, WI 54601-4782 USA
(**Email:** gate@fspa.org or **Phone:** 608-791-5283)