Student Name (LAST, First)_____

The Open School of Ethnography and Anthropology
Community Institute of Transcultural Exchange

Emergency Contact and Insurance Form

Please provide contact information for two persons who should be contacted in case of emergency

CONTACT 1

Name _____

Relationship _____

Address (include street address, city, state, zip code and country)

_____

_____

Primary Contact Phone to Call _____ cell ◯ work ◯ home/landline ◯

Second Contact Phone _____ cell ◯ work ◯ home/landline ◯

Skype_____ Email _____

CONTACT 2

Name _____

Relationship _____

Address (include street address, city, state, zip code and country)

_____

_____

Primary Contact Phone to Call _____ cell ◯ work ◯ home/landline ◯

Second Contact Phone _____ cell ◯ work ◯ home/landline ◯

Skype _____ Email _____

Insurance Information

In case of an emergency please provide all the necessary information of your insurance provider so that OSEA may contact the provider or a representative of the provider. Additional information on your policy is requested below.

_____

_____

_____

OSEA requires proof of means to assume financial costs for medical and emergency health situations. Please attach proof of insurance valid for travel and that includes emergency evacuation coverage.

I understand and agree that I, _____, as a student participant in an OSEA Training Program have full financial and moral-ethical responsibility for any and all costs that I may encumber as a result of any and all health issues, medical emergencies, personal problems or situations in which I may become involved or that may affect me. [Initials_____].

I also understand OSEA is not financially nor otherwise responsible for any medical, health or personal issue, emergency or private problem in which I may become involved [Initials_____] and I agree to not hold OSEA liable for such causes in case of such developments [Initials_____].

I therefore understand my obligation to find adequate health, medical, and personal insurance or other protection and that OSEA obliges all participants to provide evidence of the ability to maintain and see to their individual well being in such cases require medical, health or private counseling and/or services. [Initials_____].

Insurance Policy Coverage

I have [ ] have not [ ] procured insurance that will cover me during my participation in OSEA.

This insurance covers (please circle):

[yes / no] medicines.

[yes / no] cost of services by health and medical provider: does this insurance only cover services by allopathic medical doctors? [yes/no], if no specify below, and amounts or percentage:

[yes / no] emergency evacuation _____

[yes / no] hospitalization _____

[yes / no] ambulance service _____

[yes / no] dental work _____

Specify Non-Allopathic Services covered by your insurance:

[yes / no] chiropractic, [yes / no] homeopathic, [yes / no] acupuncture, [yes / no]

other: _____

This insurance is valid while in México [yes / no] and is valid during the period of time of my participation in an OSEA Training Program [yes / no]

Dates of OSEA Training Program _____ [Initials_____].

Dates of your insurance coverage _____[Initials_____].

Emergency Release/Aid

In case of medical, health, or personal/private emergency, in which I may not have full consciousness and use of reason, I grant permission to OSEA in the persons of its Directors or Staff to seek the most viable, rapid, and effective services as required by and within the limitations of such emergency conditions and situation [Initials___☐

Passport Information

Precise Name on passport _____

Number _____ Citizenship _____

Date of Birth _____ Date of Issue _____

Place of Issue _____ Expiration Date _____

Birth Place _____

Signatures

_____

Name of Participant (Print) Signature Date

_____

Name of Parent/Guardian if applicant is under 18 (Print) Signature Date