**Kawsay Center – Educación, Investigación y Conservación**

Av.26 de Diciembre 472 – Puerto Maldonado

 Madre de Dios -Perú

 Cel: +51 966381468

 Email: info@kawaycenterperu.org

Web: [www.kawsaycenterperu.org](http://www.kawsaycenterperu.org)

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REGISTRATION FORM

***Please be sure to complete as much as you can of this form before your departure, and email it to:*** info@kawaycenterperu.org and perbello25@gmail.com

**PERSONAL DETAILS**

|  |  |
| --- | --- |
| Full Name: |  |
| Date of Birth: |  |
| Passport Number: |  |
| Passport Expiry Date: |  |
| Nationality: |  |
| Permanent Address: |  |
| Phone Number: |  |
| Email: |  |
| Profession / Academic Course: |  |
| Company / University: |  |

**HOW DID YOU HEAR ABOUT US**

|  |  |
| --- | --- |
| Internet search, recommendation, website/forum, other (please give details): |  |

**EMERGENCY CONTACT DETAILS**

Please provide two emergency contacts

|  |  |  |
| --- | --- | --- |
| Name: |  |  |
| Relationship: |  |  |
| Phone Number: |  |  |
| Email: |  |  |
| Address: |  |  |

**MEDICAL HISTORY**

|  |  |
| --- | --- |
| Blood Type: |  |
| Allergies: |  |
| Food Requirements: |  |

Please indicate ‘yes’ or ‘no’ next to the following medical conditions according to whether they apply to you. If so please also include any details such as how it may affect you, any treatment received and medication that you will be bringing to manage it.

|  |  |
| --- | --- |
| HEART OR BLOODPRESSURE ISSUES: |  |
| EPILEPSY: |  |
| DIABETES: |  |
| ANAEMIA: |  |
| BACK OR NECKPROBLEMS: |  |
| MIGRANES: |  |
| ATHSMA OR OTHERRESPIRATORY ISSUES: |  |
| PSYCHOLOGICAL ISSUES(depression, anxiety etc) : |  |
| ANY DISABILITY: |  |
| ANY SIGNIFICANT STAYIN HOSPITAL OVER THEPAST 2 YEARS: |  |
| ANY MAJOR INJURYOR SURGERY: |  |
| RECURRING ISSUES(eg. ear infections): |  |

|  |  |
| --- | --- |
| Do you have any other issues that may affect you during your time with us? |  |
| Will you be bringing any other medication? |  |

Please confirm whether you are up to date with the following recommended vaccinations:

|  |  |
| --- | --- |
| TYPHOID: |  |
| TETANUS: |  |
| DIPTHERIA: |  |
| HEPATITIS A: |  |
| HEPATITIS B: |  |
| MMR: (measles, mumps and rubella) |  |
| RABIES: |  |
| YELLOW FEVER: |  |
| OTHER VACCINATIONS: |  |

**Please note that the Yellow Fever vaccination and certification is *essential* for allowance into some areas of South America.**

**FLIGHT/BUS DETAILS**

|  |  |
| --- | --- |
| **Transport method for arrival in Puerto Maldonado:** |  |
| **Date of Arrival in Puerto Maldonado:** |  |
| **Time of Arrival in Puerto Maldonado:** |  |
| **Flight Number of Arrival Flight (leave empty for bus):** |  |
| **Transport Method for Departure from Puerto Maldonado:** |  |
| **Date of Departure from Puerto Maldonado:** |  |
| **Time of Departure from Puerto Maldonado:** |  |
| **Flight Number of Departure Flight (leave empty for bus):** |  |

Please use the following space to also let us know of anything else you think might be significant for us to know:

|  |
| --- |
|  |

|  |
| --- |
| **Now, please attach a copy of your PASSPORT photo page when you email this form back to us.** |

*Thank You!*

**HEALTH - TRAVEL INSURANCE to cover you during your time with us**

**(This should be a policy that covers trekking / outdoor activity or other)**

|  |  |
| --- | --- |
| Insurance Provider: |  |
| Policy Type: |  |
| Personal Policy Number: |  |
| 24hr Emergency Insurance Number: |  |

I certify that I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) am insured under the above insurance and that the information is current and accurate. I have verified with my insurance company and/or agent that my health and accident insurance covers me in the place or country/ies where my Activity will occur and expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I hereby assume responsibility for all medical expenses I incur and all medical expenses incurred on my behalf while I participate in any activity undertaken at the Station.

I understand that I must make provisions before departure for the continuation of any medical treatments, the meeting of any special medical or nutritional needs, and the securing of any special services or facilities that I may need during my program. KC takes no responsibility for the availability or quality of any medical services or medical facilities during my participation in any activity undertaken at the Station.

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please consider:

* If you prefer you can give us this page when you arrived
* Ensure you have details of your insurance policy with you, and keep them safe during your time with us.