

Live the Osa, LLC

42 Decatur Rd.
Portsmouth, NH 03801
603-828-8251

Emergency Contact and Personal Health Information

- *Photocopy of Identification page of passport with signature
- *Photocopy of Health Insurance card
- *Explanation of Health Insurance coverage in Costa Rica
- *Additional Travel Insurance information

NAME OF PARTICIPANT: _____

Address _____

City _____ State/Province _____ Zip/Post Code _____

Day phone _____ Night phone _____

E-mail Address: _____

IN CASE OF EMERGENCY, PLEASE CONTACT

Name _____ Relationship _____

Address _____

City _____ State/Province _____

Zip/Post code _____ Country _____

Day phone _____ Night phone _____

E-mail Address: _____

SECONDARY CONTACT

Name _____ Relationship _____

Address _____

City _____ State/Province _____

Zip/Post code _____ Country _____

Day phone _____ Night phone _____

E-mail Address: _____

MEDICAL HISTORY

The following information may be needed by any hospital or medical practitioner not having access to your medical history.

Please refer to www.cdc.gov for specifics related to travel in Costa Rica and/or ask your doctor.

Allergies _____

Date of last tetanus shot _____

Physical impairments _____

Other _____

Current medications (that will be taken on trip)

Name: _____ Used for: _____ Dosage: _____

Name: _____ Used for: _____ Dosage: _____

Name: _____ Used for: _____ Dosage: _____

(For students under 18 years old)

I authorize my son/ daughter to self-administer his/her own medication, as well as any medication deemed necessary by *Live the Osa* staff and I will not hold *Live the Osa* liable for medical circumstances related to medication.

Signature of Parent:

I will be responsible for taking my own medication and I will keep track of my intake of medication and let staff know any medical needs or concerns.

Signature of Student:

PERSONAL PHYSICIAN

Name _____

Address _____

City _____ State/Province _____ Zip/Post Code _____

Day phone _____ Night phone _____

Email _____

PRIMARY HEALTH INSURANCE COVERAGE

Company _____ Policy Number _____

Insurance Agent _____ Agent's phone _____

Primary beneficiary _____ Relationship _____

Secondary beneficiary _____ Relationship _____

Please call your insurance company to answer the following questions:

Will you be covered under this insurance in Costa Rica? _____

Does your insurance cover medical evacuation expenses abroad? _____

What is the process for an international claim? (Contact information, time frame to make a claim, type of receipt needed, etc.)

SECONDARY HEALTH INSURANCE COVERAGE (TRAVEL INSURANCE)

Company _____ Policy Number _____

Insurance Agent _____ Agent's phone _____

Primary beneficiary _____ Relationship _____

Secondary beneficiary _____ Relationship _____

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Other Medical Related Comments: