MOUNTAIN SPIRITS

REGISTRATION FORM

RETURN ASAP TO MTN. SPIRITS WITH

· LIABILITY RELEASE FORM ·PASSPORT PHOTOCOPY

NAME (*as it appears on passport*) _____
PASSPORT #_____ EXPIRATION DATE _____
ADDRESS _____
CITY _____ ST _____ ZIP _____
PHONE # _____ PHONE #_____
E-MAIL_____

DATE OF BIRTH_____ HEIGHT_____ WEIGHT_____ M· F ·

EMERGENCY CONTACT:_____PHONE_____
EMERGENCY CONTACT:_____PHONE_____

Insurance Information

MEDICAL INSURANCE :_____POLICY #_____
TRAVELER'S INSURANCE:_____ POLICY #_____
*(*traveler's insurance including medical/evacuation is required for all trips)*

Mountain Spirits Cancellation Policy

Deposit for Trip Non-Refundable (Transferable)
If cancellation occurs *more than 90 days* prior to trip start date, trip cost refundable *less* deposit.
If cancellation occurs *less than 90 days* prior to trip start date, trip cost non-refundable.

Travel Information

ARRIVAL DATE _____TIME _____AIRLINE _____FLIGHT #_____
DEPARTURE _____TIME _____AIRLINE _____FLIGHT #_____

Accommodations

· I AM TRAVELING WITH _____
· I WOULD LIKE TO SHARE ACCOMODATIONS WITH _____
· I WOULD LIKE SINGLE ACCOMODATIONS ($250 additional charge)

SIGNATURE_____ **DATE**_____

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TRIP PARTICIPANT'S RESPONSIBILITY ~ please read & initial

Trip participants are responsible for any expenses incurred for either having to leave the trip early or for trip schedule being changed &/or delayed (i.e. departure) due to weather and/or other unforeseen circumstances. Initial:_____

Trip participants are responsible for selecting a trip appropriate to their abilities and are held responsible for being in sufficient good health to undertake the trip. Initial:_____

Trip participants are requested to be well informed of current State Department travel bulletins and or travel warnings: www.travel.state.gov/travel_warnings.html Initial:_____

MEDICAL QUESTIONNAIRE

Please understand that it is required as a trip participant that you advise Mountain Spirits of any existing physical or medical condition that might require attention or that will hinder your ability to safely participate in a trekking trip.

Please fill out information below (IN LAYMAN"S TERMS). This will help to alert us to any special dietary or medical conditions we should be aware of. *This information will be kept confidential.*

Are you taking any medication? Yes_____ No_____
Name of Medication: _____
Describe medical condition:_____

Are you allergic to any foods, medicines or other allergens? Yes_____ No_____
Please LIST:_____

Have you ever had an anaphylactic allergic reaction? Yes_____ No_____
To what?_____
Do you carry an EPI pen or similar product? Yes_____ No_____

Do you have any current medical conditions? Yes____ No_____
Describe condition:_____

DIET

Do you have dietary restrictions or requests? Yes____ No____
List:_____

I understand my responsibilities as a Trip Participant and I certify that the information I have provided is complete and correct to the best of my knowledge.

_____ _____
Signature Date

_____ _____
Witness Date

PLEASE RETURN TO MOUNTAIN SPIRITS
PO BOX 3689, Hailey, ID 83333

Thank you!