THE BELIZE VALLEY ARCHAEOLOGICAL RECONNAISSANCE PROJECT

Certification of Adequate Insurance Coverage
Medical Treatment Authorization and Medical History

Name: _____
(Exactly as it appears in your passport)

Address: _____ (Street)
_____ (City, State, Zip)
_____ (Country)

SSN: _____ (Social Security Number)

Passport No.: _____ (Exactly as it appears on your passport)

Phone: (____)_____ (Primary contact number)

Please strike out the inappropriate terms within the parentheses below and sign the **Certification of adequate insurance coverage**, the **Certification of good health** and either the **Authorization and consent** or the **Non-consent**. Complete the **Medical history** and sign the certification that follows it. An adult should sign on his or her own behalf. The parent or legal guardian must sign on behalf of a student who is a minor.

Certification of adequate insurance coverage:

This is to certify that (I have / my child has) evacuation coverage.

Insurance Company: _____ **Policy #:** _____

Signature: _____ **Date:** _____

Certification of good health:

I hereby certify that (I am / my child is) in good health, that I understand the physical requirements of the *Belize Valley Archaeological Reconnaissance Project Field School,* and that (I / he / she) can travel with and participate in this Belize Valley Archaeological Reconnaissance Project function.

Signature: _____ **Date:** _____

Authorization and consent

While (I am / my child is) participating in this program, I HEREBY AUTHORIZE THE INSTRUCTOR, or in his or her absence or disability, any adult accompanying or assisting him or her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR (ME / HIM / HER) SHOULD (I / HE / SHE) BE UNABLE TO MAKE A DECISION:

Any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed in the appropriate jurisdiction; or any X-Ray examination, anesthetic,

dental or surgical diagnosis or treatment or care to be rendered by a dentist licensed in the appropriate jurisdiction.

Signature: _____ **Date:** _____

Non-consent

I do not desire to sign this authorization and understand that this may hinder or prohibit my receiving medical attention in the event of illness or accident.

Signature: _____ **Date:** _____

Please contact the following person(s) in the event of an emergency:

Name: _____ **Day phone:** (____)_____
Address: _____ **Night phone:** (____)_____
_____ **Relationship:** _____

Name: _____ **Day phone:** (____)_____
Address: _____ **Night phone:** (____)_____
_____ **Relationship:** _____

Name: _____ **Day phone:** (____)_____
Address: _____ **Night phone:** (____)_____
_____ **Relationship:** _____

Physician:
Name: _____ **Day phone:** (____)_____
Address: _____ **Night phone:** (____)_____
_____
_____

Medical History

Submission of the following medical data is voluntary and will be held in confidence by the BVAR staff. Your responses to the following questions are solely to be able to provide accurate information to providers of medical care. Your participation in the BVAR Field School is in no way dependent upon your responses. However, if you fail to provide the medical information and authorization it may be difficult or impossible to secure appropriate medical treatment.

Date of birth: _____ **Blood type:** _____

Vaccinations:

When were you vaccinated for?

Diphtheria		Smallpox	
Typhoid		Tetanus	
Polio		Measles	

Allergies:

Please identify your allergies, including allergies to food, medications or drug reactions that you know about:

_____
_____
_____
_____
_____

Medications:

Please list all medications that you are presently taking:

Name of Medication	Dosage	Times taken

Limitations:

Please list any physical limitations or disorders that may limit your activities at this University function, such as eyesight, hearing, speech, paralysis, diabetes, ulcer, etc.

_____
_____
_____
_____
_____

Remarks and special instructions:

_____
_____
_____
_____
_____
_____
_____

I hereby certify that the information provided above is true and complete to the best of my knowledge.

Signature: _____ **Date:** _____