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Registered as a Close Corporation: 2009/177240/23

## REGISTRATION FORM

Today's Date: \_\_\_\_\_

Destination: \_\_\_\_\_

**PLEASE PRINT**

TITLE:	Mr	Mrs	Miss	Dr	Other
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Surname: \_\_\_\_\_

Name: \_\_\_\_\_

Postal Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Residential Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Contact Numbers:

(\_\_\_\_) \_\_\_\_\_ (Work)

(\_\_\_\_) \_\_\_\_\_ (Home)

\_\_\_\_\_ (Cell)

\_\_\_\_\_ (E-mail)

Date of Birth: \_\_\_\_\_

ID Number: \_\_\_\_\_

Passport number: \_\_\_\_\_

Date of issue: \_\_\_\_\_

Expiry date: \_\_\_\_\_

## MEDICAL QUESTIONNAIRE

<p>Height: _____</p>	<p>Weight: _____</p>		
<p>Do you have any physical condition which may limit your ability to perform for what you have applied.</p>	<p>If yes, please explain:</p>		
<table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table>	YES	NO	
YES			
NO			
<p>Do you have any chronic illness or allergies?</p>	<p>If yes, please explain:</p>		
<table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table>	YES	NO	
YES			
NO			
<p>Do you have any psychological illness (e.g. depression, schizophrenia, etc)</p>	<p>If yes, please explain:</p>		
<table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table>	YES	NO	
YES			
NO			
<p>Do you have any special dietary needs?</p>	<p>If yes, please explain:</p>		
<table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>YES</td></tr> <tr><td>NO</td></tr> </table>	YES	NO	
YES			
NO			

Are you currently taking or do you regularly take any chronic medication?	YES	If yes, please explain:
	NO	

Contact information in the case of an emergency:

Doctor's Name:	Tel Number:
Other contact name and surname:	
Relation:	Tel Number:

# LIABILITY RELEASE AGREEMENT

## INDEMNITY FORM

**TO BE COMPLETED BY PERSON OVER 21**

I, \_\_\_\_\_ the undersigned, do hereby forfeit any claim whatsoever against Adventure and Cultural Tours, which I, my heirs, dependants, administrators, executors might have due to any public violence, political uproar, arrest, deportation or any other cause of attack, accident, sickness and/or injury and/or loss of, or damage to belongings, or any consequential loss of any nature of cause whatsoever, which may arise during or forthcoming from my involvement with Adventure and Cultural Tours, FROM (day) \_\_\_\_\_ Month \_\_\_\_\_ 20\_\_ TO (day) \_\_\_\_\_ Month \_\_\_\_\_ 20\_\_ I will submit to the leadership, policy and procedures of Adventure and Cultural Tours as communicated to me. I authorize Adventure and Cultural Tours, in the event of injury, to give permission for emergency medical treatment and I agree that I will be responsible for the full payment of such treatment. I hereby confirm that I have read the above statement and that I fully understand the contents and consequences of this indemnity form.

THUS SIGNED AT \_\_\_\_\_ ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_ OF 20\_\_

Signature: Participant

Witness 1
Witness 2

**TO BE COMPLETED BY PERSON UNDER THE AGE OF 21**

I, \_\_\_\_\_ the undersigned, hereby assisted by my parent(s) or legal guardian \_\_\_\_\_ do hereby forfeit any claim whatsoever against Adventure and Cultural Tours, which I, my heirs, dependants, administrators, executors might have due to any public violence, political uproar, arrest, deportation or any other cause of attack, accident, sickness and/or injury and/or loss of, or damage to belongings, or any consequential loss of any nature of cause whatsoever, which may arise during or forthcoming from my involvement with Adventure and Cultural Tours, FROM (day) \_\_\_\_\_ Month \_\_\_\_\_ 20\_\_ TO (day) \_\_\_\_\_ Month \_\_\_\_\_ 20\_\_ I will submit to the leadership, policy and procedures of Adventure and Cultural Tours as communicated to me. I authorize Adventure and Cultural Tours, in the event of injury, to give permission for emergency medical treatment and I agree that I will be responsible for the full payment of such treatment. I hereby confirm that I have read the above statement and that I fully understand the contents and consequences of this indemnity form.

THUS SIGNED AT \_\_\_\_\_ ON THE \_\_\_\_\_ DAY OF \_\_\_\_\_ OF 20 \_\_\_\_\_

Signature: Parent/Guardian

Witness 1

Witness 2

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