



MEDICAL DISCLOSURE & PARTICIPANT HEALTH DECLARATION

This form is confidential and will be used only in the event of a medical emergency or to ensure participant safety during travel.

Participant Information

Full Name: _____
Date of Birth: _____
Passport Number (optional): _____
Address: _____
City/State/ZIP: _____
Phone: _____
Email: _____

Emergency Contact

Name: _____
Relationship: _____
Phone (Primary): _____
Phone (Alternate): _____

Medical Information (Confidential)

Please disclose any medical, physical, or psychological conditions that may affect your ability to safely participate in international travel, group activities, variable climates, or limited medical access in India.

- ☐ No known medical conditions
- ☐ Allergies (food, medication, insect, environmental):
- ☐ Chronic medical conditions (e.g., asthma, diabetes, heart conditions, autoimmune conditions):
- ☐ Recent surgeries, injuries, or hospitalizations (past 12 months):
- ☐ Mobility limitations or special accommodation required:



☐ Mental health conditions that may require support while traveling:

Medications

Please list all current medications (include dosage and frequency):

Do you carry emergency medication (EpiPen, inhaler, insulin, etc.)?

☐ Yes ☐ No

If yes, please specify: _____

Physician Information (Optional)

Physician Name: _____

Phone: _____

Travel Health Acknowledgement

I acknowledge and understand that:

Travel to India may involve extreme heat, high humidity, altitude changes, different food and water standards, and variable access to medical facilities.

I am responsible for obtaining recommended vaccinations, preventive medications, and travel medical insurance prior to departure.

I certify that I am medically fit to participate in this program organized by Soul India Journeys LLC.

Authorization for Emergency Medical Treatment

In the event of illness, injury, or medical emergency, I authorize Soul India Journeys LLC, its partners operators in India, guides, and representatives to obtain emergency medical treatment on my behalf if I am unable to provide consent.

I understand that I am financially responsible for all medical care, evacuation, medications, or related expenses incurred.

Disclosure, Assumption of Risk & Liability Statement



I certify that the information provided in this form is true, complete, and accurate to the best of my knowledge. I agree to notify Soul India Journeys LLC of any changes to my medical condition prior to departure.

I understand that failure to disclose relevant medical information may result in removal from the tour program if my continued participation is deemed unsafe for myself or others.

Signature

Participant Signature: _____

Print Name: _____

Date: _____

If participant is under 18 years of age:

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____