Medical Insurance Information and Medical Waiver

The University of Texas Archaeological Field School in Belize

COMPLETE THIS FORM IN INK

The University of Texas Archaeological Field School in Belize and its affiliates or their past or present officers, directors, employees, and agents (hereafter “the Project”) do not engage directly or indirectly in diagnosing, dispensing medical advice, endorsing, recommending, or prescribing the use of any product, therapy or service as a preventative measure or as a treatment for disease or sickness whether physical or mental. Information provided by the Project is not intended to be medical advice and should not be relied on as such.

We may offer health information for education purposes only in an effort to help you cooperate with the health professional of your choice. It is important that you communicate with your physician or health care provider so that together you can integrate pertinent information, such as age, ethnicity, health history, signs and symptoms, laboratory and other procedures (for example immunizations, prescriptions), to determine the best course of action prior to and during your participation in the Project. The information provided through the Project is not intended to substitute for such consultation with your physician or health care provider, nor is it specific medical advice regarding your health concerns.

Before acting on any information provided by the Project, you agree to thoroughly review and discuss any such information with all of your attending medical practitioners to determine which information or course of action is appropriate for you, based on your personal medical history, current medications, lab results, and physical level of functioning. You agree never to disregard professional medical advice or delay seeking it because of any information you ever receive or have ever received from the Project.

You exercise your own judgment when purchasing any product or selecting any course of medical treatment, following prescriptions, or undergoing immunizations. Medical information changes rapidly and therefore, some information, regardless of source, may be out of date, and/or contain inaccuracies or typographical errors.

Always seek the advice of your physician or other qualified health provider with any questions you may have regarding the appropriate course of action with respect to your participation in the Project. Never disregard professional medical advice or delay in seeking it because of something you have read in Project information.

Participation in the Project requires international travel medical insurance including, but not limited to medical evacuation (sometimes termed “return to point of origin”).

Your insurance carrier name: ____________________________________________________________

Policy number: __________________________________________________________________________

Effective dates of policy: __________________________________ until: __________________________

Insurance carrier mailing address: __________________________________________________________________________

____________________________________________________________________________________

Insurance carrier collect calling telephone number for emergencies:

__________________________________________

DO NOT LIST A TOLL-FREE (800) NUMBER HERE. YOU CANNOT CALL TOLL-FREE NUMBERS FROM BELIZE

__________ (initials) After having read and completed this page, initial here and go on to page 2
The University of Texas Archaeological Field School in Belize, Medical Waiver

Please write your initials in each space below after reading and agreeing to each statement.

_______ (initials) I certify that my insurance policy covers me for medical evacuation (return to point of origin) if deemed medically necessary.

_______ (initials) I have included with this signed document a photocopy of the page(s) of my written insurance policy that states that medical evacuation (return to point of origin) is included in my policy. I understand that this photocopy is required.

_______ (initials) I understand that my insurance may not be accepted by health care providers in Belize, Guatemala, or the USA, and that I may have to pay for medical services and medications in advance with cash or a major credit card. I agree that it is my sole responsibility to pay in full for any and all medical services and medications and to negotiate claims with my insurance carrier as required in the stipulations of my insurance policy. I understand that procedures may have to be approved by my insurance carrier in advance, even if I pay for them in advance and cannot file a claim until after I return home.

_______ (initials) It is in no way the responsibility of the Project to determine the adequacy of my insurance coverage.

_______ (initials) I understand that my claims may be denied by my insurance carrier and I hereby release and indemnify the Project against any and all liability resulting from medical claims.

The Project disclaims any liability arising out of your use of any information provided and for any adverse outcome from your use of the information provided by the Project for any reason, including but not limited to any misunderstanding or misinterpretation of the information provided by the Project. You understand and agree that all information provided by the Project bears no personal or legal responsibility for any consequences thereof. You are willing to personally accept the risks inherent with your healthcare, including, but not limited to, financial risks.

By signing below you agree to waive, release, and hold harmless the Project and its affiliates or their past or present officers, directors, employees, and agents from any legal claims, rights, or causes of action you may have in connection with the information that we may provide you. You hereby release the Project from any and all claims, demands, damages, actions, causes of action, suits in equity, and liability of whatever kind or nature, including negligence. This release is intended to cover, without limitation, personal, bodily, or property injury of any kind.

I declare that I am eighteen (18) years old or older and am legally competent to execute this agreement or that I have acquired the written consent of my parent or guardian. I understand that the terms herein are contractual and not a mere recital, that this instrument is legally binding, and that I have voluntarily signed this document. I have fully informed myself of this document before signing it.

Print your name: _______________________________________________________

Your signature: _______________________________________________________

Date: _______________________________

Print witness’ name: ___________________________________________________

Signature of witness: ___________________________________________________

Your address: ______________________________________________________________________