Name:

PARTICIPANT FORM



Age: Gender: Date of birth:

Nationality: VAT number:

ID Number: Expiration date:

Health Insurance Policy Number:

Address:

ZIP Code: Country:

Emergency contact: Your contact:

ADDITIONAL INFORMATION: MEDICAL INFORMATION

DO YOU HAVE ANY KIND OF MEDICAL CONDITION/DISABILITY IMPAIRMENT, WHICH REQUIRES HEALTH CARE?

ADDITIONAL INFORMATION: ALLERGIES

ARE YOU ALLERGIC TO ANY TYPE OF FOOD? IF SO, WHICH?

DO YOU HAVE ANY OTHER ALLERGIES? (INSECTS, POLLEN…)

OTHER INFORMATIONS YOU CONSIDER RELEVANT

Examples: Vegetarian, vegan…

WE WOULD ALSO LIKE TO KNOW…

WHAT’S YOUR MOTIVATION TO PARTICIPATE IN THIS EXCHANGE?

WHAT’S YOUR OPINION ABOUT THE THEME GENDER EQUALITY IN YOUR COUNTRY?

CONSENT

I AUTHORIZE THE COLLECTION, PROCESSING AND UTILIZATION

OF MY PERSONAL DATA BY ASSOCIAÇÃO PARA O PLANEAMENTO **YES** **NO**

DA FAMÍLIA, ONLY AND EXCLUSIVELY FOR THE PROGRAM

ERASMUS+ JUVENTUDE EM AÇÃO. THIS CONSENT CAN BE

WITHDRAWAL AT ANY MOMENT.