SUU Learning Abroad

MEDICAL INFORMATION FORM

PERSONAL INFORMATION

Full Name :

Date Of Birth : _____/_____/_____

Address : _____

Phone Number : _____ **E-Mail** : _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Home Number** : _____

Relationship : _____ **Mobile Number** : _____

INTERNATIONAL TRAVEL AND TREATMENT

Are you covered under a health care or medical insurance plan that includes international travel and medical treatment outside the U.S. ?

☐ **Yes. Attach a copy of your insurance card**

☐ **No. Please purchase international insurance recommended by the Office of Learning Abroad (see website) or another international insurance similar or better coverage. Attach proof of purchase.**

☐ ***I am taking a part in a faculty/staff-led short-term study abroad program through the Office of Learning Abroad.*** **The Office of Learning Abroad purchases international insurance on behalf of these students.**

INJURIES, OPERATIONS, ILLNESSES OR PHYSICAL CONDITIONS

Do you have any injuries, operations, illnesses or physical conditions that should be disclosed to the Office of Learning abroad prior to traveling abroad?

☐ **Yes (List the conditions i.e. high blood pressure, heart disease, diabetes etc...)**

☐ **No. No medical information needs to be disclosed at this time.**

MEDICATION

Are you under a doctors' order for any medication?

☐ **Yes (List the medications and/or needs related to the medications below)**

☐ **No. No medications need to be disclosed at this time.**

ALLERGIES

Do you have any allergies?

☐ **Yes (List the allergies)**

☐ **No. No allergies need to be disclosed at this time.**

OTHER DISCLOSURES

Do you have any perceptual disabilities (e.g. dyslexia), emotional or mental health challenges, or other medical or health concerns that should be disclosed to the Office of Learning Abroad?

☐ **Yes (List the conditions)**

☐ **No**

STATEMENT

I authorize the SUU Program Director, or his/her authorized representative, to consent to x-ray, examination, anesthetic, medical or surgical or dental diagnosis or treatment, and hospital care to be rendered to me under the general or special supervision and advice of any dentist, physician, or surgeon licensed to practice when they need for such treatment is immediate and when efforts to reach emergency contracts are unsuccessful.

I agree to pay all charges incurred for the treatment of illness or injury myself. I understand that I have primary responsibility for the payment of all charges, whether or not I am covered by health or medical insurance.

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Name (Printed): _____ **Phone:** _____

Signature: _____ **Date:** _____

Address: _____

(Street) (City/State) (Zip Code)

IF TRAVELER IS UNDER THE AGE OF 18

_____

Name of Guardian in Print

_____

Signature of Guardian Date of Signature