

**Health Information and Emergency Treatment Form**

Please answer each of the questions below. It is in your best interests to provide a candid evaluation of your physical and emotional health. We hope to create an awareness of any health issues to be taken into consideration before you go and as needed while abroad. We appreciate your cooperation in completing this form and adding any information that you feel is relevant to your well-being and participation in the program.

Submit this original completed document to along with your application and keep one on your person at all times. If on religious or other grounds the student or her/his parent/guardian is unwilling to sign the Permission for Emergency Medical Authorization and Release, a written explanation signed by both the participant and her/his parent or guardian must be attached and returned to the International Education Center.

**Student’s Name \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program**

**If you answer “yes” to any of the following questions, please use the space indicated or a separate sheet to provide details.**

**General Health & Medications**

1. Will you require any medical attention while abroad, or do you have any conditions (including dietary restrictions) which may affect your participation in the program? no yes

1. Do you have any medical conditions which may, under stress or duress, require immediate medical attention during your participation in the program, e.g., epilepsy, heart trouble, asthma, ulcers, hemophilia, diabetes, past illness? no yes
2. Do you have any conditions or impairments which may affect your emotional or mental well-being during your participation in a study abroad program? no yes

If so, what kind of accommodations or support might be needed (e.g., classes, counselors, signers)?

1. What treatments or prescribed medications do you currently receive on a regular basis? If none, mark N/A.
2. Will you be able to perform the essential functions of this study abroad program? no yes

If you are a person with a disability and would require a reasonable accommodation to perform the essential functions of this study abroad program, please contact the Director of Disability Services at SSU before submitting this form.

1. What is your blood type (if known)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

7. Do you have any dietary restrictions or known food allergies? \_\_\_\_\_no \_\_\_\_\_yes If so, please explain:

Are you allergic to any of the following? \_\_\_\_\_no \_\_\_\_\_yes If so, please check appropriate line:

\_\_\_\_\_ Penicillin \_\_\_\_\_Aspirin \_\_\_\_\_Sulfa \_\_\_\_\_Local anesthetic

8. Do you have any other allergies (e.g., bee stings, environmental) \_\_\_\_\_no \_\_\_\_\_yes If so, please explain:

**Emergency Contacts**

Name (and relationship to you): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone(daytime): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Contact** (this person will be contacted if your primary contact is not available)

Name (and relationship to you): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone(daytime): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Medical Authorization and Release**

On occasion, emergencies arise which may require medical care, hospitalization or surgery for a program participant. In order for such treatment to be administered without delay, we ask that participants sign the following statement authorizing Savannah State University to secure, at the expense of the participant, any treatment deemed necessary.

*In the event of injury or illness, if I am unable to do so myself, I hereby authorize the Resident Director or other official appointed by Savannah State University at my expense, to secure any necessary treatment, including administration of anesthetic and surgery, and such medication as may be prescribed. It is further agreed that, if my condition so requires, I may be evacuated to the United States at my own expense.*

*I hereby release Savannah State University and/or any cooperating institution and their officers and agents from any and all claims and causes of action for damage to or loss of property, medical or hospital cares, personal illness or injury, or death arising out of any travel or activity conducted by or under the control of Savannah State University or cooperating institutions.*

I have read all the information on this form. I certify that the information I provided on this sheet is true and correct to the best of my knowledge. I consent to the Authorization and Release. I understand that this information may be shared with my program provider, program leader or host institution.

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_