Health and Emergency Information

Please use a black or blue pen and print clearly. A photocopy of this form will be kept in International Student Services, Student Center 237. The original will be in the possession of the Program Director for the duration of the experience**.** This record will be destroyed upon completion of the experience.

Full Name:

_____

Last **First** **MI**

Student ID #:

_____

Passport #:

_____

Program:

_____

Dates of Departure/Return:

_____/_____

The purpose of this form is to allow Southwest Minnesota State University to be of maximum assistance to you should the need arise during your study/travel experience. Mild disorders can become serious under the stresses of studying and traveling. It is important that SMSU be made aware of any medical or emotional problems, past or current, which might affect you while participating in a study/travel program. The information provided will remain confidential. Attach to this form a copy of your passport ID/signature page.

Emergency Contact 1

Name:_____

Relationship:_____ **Main phone:**_____

Other phone:_____ **Email:**_____

Emergency Contact 2

Name:_____

Relationship:_____ **Main Phone:**_____

Other phone:_____ **Email:**_____

Primary Health Care

Provider/Physician:_____

Name of Primary Health Care Facility:_____

Phone:_____

Address of Primary Health Care Facility:

_____

Insurance Provider (in addition to Student Health):

_____

Policy Number:_____

Name on Policy:_____

You are required to have health insurance to participate in a SMSU sponsored study/travel program. Insurance must include coverage for repatriation of remains and medical evacuation. You will be required to purchase international travel health insurance.

1. Are you in good physical condition? YES_____ NO_____

   (If no, please explain.)_____

   _____

2. List current medications:_____

   _____

3. List any known allergies:_____

   _____

4. Medical concerns (Please make available any information that would be helpful for the program director to be aware of during your study/travel experience.):

   _____

   _____

5. We are committed to meeting the needs of people with disabilities. If you check YES, we will contact you on how we can best meet your needs. YES_____
6. Do you have any dietary restrictions? YES_____ NO_____ (If yes, please explain.)

   _____

   _____

I certify that all responses made regarding health information and health insurance are true and accurate, and I will notify the School of any relevant changes that may occur. I understand that (School) is not liable for any re-occurring or pre-existing medical conditions.

Print Student Name:_____

Student Signature:_____

Date:_____

Parent/Guardian Signature (if participant is under 18 years of age):

_____Date:_____