FOREIGN TRAVEL INSURANCE CONFIRMATION AND MEDICAL INFORMATION

Name of Participant: _____SS#: _____
Program(Activity/Travel Course):_____Pgm Date(s):_____

In case of emergency, please notify:
Name:_____ Relationship:_____ Phn #:_____

INSURANCE CONFIRMATION (MANDATORY):

(You are required to have adequate health insurance. If you have health insurance through a family or other plan and it includes coverage for travel abroad, including repatriation and medical evacuation expense, then you must complete the section below and provide a copy of your insurance card/certificate. If you do not have such health insurance, then you must purchase the University-sponsored Travel Insurance or International Student Accident & Sickness Insurance Plan.)

Health Insurance Company:_____ Policy #:_____
Insured:_____ Phn #:_____

Does this policy cover you for the period of the travel Program listed above? _____
Does this policy afford coverage for foreign travel, including medical evacuation and repatriation expenses?
_____
Do you understand your policy and its terms and limitations? _____

MEDICAL INFORMATION: (Please answer the following questions)

Do you have any physical handicaps that would limit your travel and/or participation in this travel Program? (If yes, please describe)

Are you currently taking medication? (If yes, please give details)

Do you require regular medication? (If yes, please specify)

Do you have any allergies to medications or foods, or any dietary restrictions? (Please describe)

Please provide any other information relevant to your health which may be necessary for your Program coordinator to know during your travel.

AUTHORIZATION:

I acknowledge that the insurance confirmation and the health history is correct, that I am in good health, and that I have no physical conditions that affect my ability to travel and/or participate in any of the activities involved in the above-referenced program. I understand that I am responsible for notifying the Program coordinator immediately of any injury, sickness or other medical condition or change to the medical information herein provided.

_____ _____
(Signature of Participant) (Date)

Parent/Guardian must sign if Participant is under 21 years of age.

_____ _____
(Signature of Parent/Guardian) (Date)