STONEHILL
COLLEGE

Domestic/International Travel Medical Statement

revised 7/14/2010

The purpose of this form is to help Stonehill College provide appropriate assistance to you should the need arise during your travel experience. It is important that we be aware of any medical problems (past or current), including mental health conditions, which might affect your ability to participate in the program. This information will be kept confidential in accordance with the law. Any disclosure of such information will be made only to appropriate individuals, and handled with the highest level of discretion in order to protect your privacy. Relevant information will be shared with program staff, leaders, or appropriate professionals as it relates to your health and safety.

Please be on notice that certain health tests, screenings, and vaccinations may be recommended, and in some cases required, prior to participation in certain programs.

Your Name:	First Middle Last		
Sex:	❒ male ❒ female	Date of birth: / /	Citizenship:
Email:			
Campus Address:			
Home Address:	Street city state zip		
Contact Information:	Home phone:	Cell phone:	
Name of Program:			
Country(ies) or State(s)of Program:	Please indicate closest major city		
Allergies/Dietary Restrictions:	List all medication, food, or other allergies, as well as dietary restrictions		
Medication:	List all medications taken on a regular or as needed basis, indicate how often taken and why taken.		
Other Health Conditions:	List any other health conditions which you feel may be important for health care providers/responsible individuals to know in the event of an emergency.		
Emergency Contacts:	In the case of an emergency, the College will make every attempt to notify the following people: Name and Relationship:	Phone:	Cell:
	Name and Relationship:	Phone:	Cell:

1. Disabilities. I understand that if I have a disability, I may be eligible for accommodations to facilitate my participation in my program. If I wish to request an accommodation I understand that I must contact the Stonehill College Center for Academic Achievement at least 8 weeks prior to my scheduled departure date in order to discuss any requested accommodations. I understand that failure to provide Stonehill College the necessary time to evaluate, research, and implement accommodations may affect my ability to participate fully in my desired program.

2. Health and Emergency Authorization. I authorize Stonehill College, through its agents and representatives, to release any and all information contained in this form to any and all appropriate health care professionals or other appropriate individuals in connection with health, welfare, and medical treatment. In the event that I need emergency medical care, hospitalization, or surgery while participating in the program, I authorize Stonehill College to secure any necessary treatment. In some cases, access to medical care may be more than 24 hours away and services may be limited. I certify that all responses made on this form are complete, true and accurate, and I understand that if there are any changes in my health status, I will complete and submit an updated form.

3. I understand that I am required to maintain adequate health, accident, disability, hospitalization, and travel insurance during my participation in this program and that I must provide Stonehill College documentation and proof of insurance prior to my departure, such proof may include a photocopy of the back and front of my health insurance card. Extension Program participants: My insurance policy ☐ will or ☐ will not provide coverage for the duration of my program. List primary and secondary insurance information below.

   Health Insurance Information:

   Subscriber's Name: _____

   Insurance Company: _____ Policy Number: _____

   Insurance Company Telephone Number: _____

   Secondary Insurance Company: _____ Policy Number: _____

   Insurance Company Telephone Number: _____

4. I give permission for my primary care doctor to be contacted if medically necessary to obtain health information in an emergency:

   Name of Doctor: _____ Telephone Number: _____

5. Release of Claims and Indemnity. I acknowledge that I have read, understand, and signed the Stonehill College Acknowledgment of Risk and General Release Form and said form is incorporated herein by reference.

6. Governing Law. Any dispute arising from this Agreement will be determined according to Massachusetts law.

In signing this document I acknowledge that I have had an opportunity to ask any questions I have about it, that I have read and understand it, that I accept its terms, and that I have signed it knowingly and voluntarily. If applicable, I also understand that if I am considered a financial dependent for financial aid purposes, that Stonehill College will provide a copy of this form to the parent or parents claiming me as such.

Participant's Signature: _____ date:_____

Printed Name: _____

Parent/Legal Guardian's Signature : _____ date:_____
(required if participant is under age 18 or is claimed as a dependent for insurance purposes)

Printed Name: _____