POLK STATE COLLEGE

STUDY ABROAD MEDICAL & EMERGENCY INFORMATION FORM

I. PARTICIPANT INFORMATION			
Name:		**Date of Birth:**	
Address:		**Cell Phone:**	
City / State / Zip:		**Email:**	
II. EMERGENCY CONTACT INFORMATION: ***List two emergency contacts.***			
Name:		**Name:**	
Relationship:		**Relationship:**	
Home Phone:		**Home Phone:**	
Work Phone:		**Work Phone:**	
Cell Phone:		**Cell Phone:**	
Email:		**Email:**	

III. MEDICAL QUESTIONNAIRE
Do you have any permanent health conditions, physical or psychological/mental, that could significantly interfere with your ability to travel on this program? If so, please describe those conditions and any assistance or accommodation you require.
Are you mentally and physically able, with or without assistance or accommodation, to fulfill the expectations of this study abroad program?
Do you have any allergies? If yes, please describe them and whether you expect them to be an issue while traveling.
Are you a vegetarian? Do you have any special dietary needs?
Identify any prescription that you may need to take while traveling, and confirm that you will have sufficient dosage to last throughout the program.
Do you anticipate the need for any health care or counseling while abroad? Please explain.

If you are on prescription medication, you should have your doctor write you a note and give you an extra prescription to take with you to fill overseas in the event that you run out or it becomes lost.

I certify that the information above is complete and correct. I hereby grant the College and its agents full authority to take whatever actions they may consider to be warranted under the circumstances concerning my health and safety, and I fully release each of them from any liability for such decisions or actions as may be taken in connection therewith. I authorize the College and its agents, at their discretion, to place me, at my own (or my parent's or guardian's) expense, and without my further consent, in a hospital within or without the United States of America for medical services and treatment, or if no hospital is readily available, to place me in the hands of a local medical doctor for treatment. If deemed necessary or desirable to Polk State College or its agents, I authorize them to transport me back to the United States by commercial airline, and I assume responsibility for expenses involved. Any funds advanced to me for any purpose will be reimbursed upon demand by either myself or my parents or guardian.

Signature:		**Date:**	