MEDICAL RELEASE/EMERGENCY CONTACT INFORMATION/INSURANCE FORM
Travel Component

Students must complete this form and parents/guardians must consent for treatment by signing page 2

_____ _____
Student's Name (Please Print) Title of Program/Course

I understand that I am required to have adequate health, accident, and hospitalization insurance, including medical evacuation and repatriation, to cover myself while traveling to and from the off campus study program location and during participation in the program and any program excursions. I have arranged for adequate insurance to meet any and all such needs and provide details of this coverage below.

I further agree to accept all financial responsibility for such medical treatment and related services as I may incur or that may be incurred on my behalf while on the program. If I require medical care while on the program, I will pay the bills on site.

I have verified with my insurance company that I have accident and sickness coverage, and medical evacuation and repatriation coverage

Health Insurance Company _____

Policy Number _____

In case of an emergency, the following parents/guardians should be notified:

_____	_____
Name	Name
(_____)_____	(_____)_____
Phone	Phone
_____	_____
E-Mail	E-Mail
_____	_____
Mailing Address	Mailing Address
_____	_____
City State Zip	City State Zip

In the event that I, _____ , require medical care during my travel off-campus, I authorize the faculty director of my program to contact my parent(s) or legal guardian. I further authorize the release by CIIS and the Torrey Health Center staff of my medical records and other information regarding my health status to health care professionals responsible for my care, my parent(s) or other designated contact persons.

In the event that I am unable to give consent to medical care myself during an emergency, and/or my parents/guardians cannot be reached in a timely manner, I hereby give, to the program faculty director or a duly appointed representative consent to care for me, including consent to make decisions for medical and surgical treatment and hospitalization.

Signature _____ Date _____

PARENT OR LEGAL GUARDIAN ACKNOWLEDGEMENT

I, _____ , the parent or legal guardian of _____, have reviewed and discussed this medical release and permission for emergency medical treatment form with my child/ward. Further, I have verified that my child/ward will be adequately covered while abroad by the insurance company stated above.

_____ Date _____

Parent/Legal Guardian Signature

Participant Health Questionnaire:

Please check if you have, have had, and/or have ever been treated for any of the following conditions:

◯ Acne	◯ Ear infections	◯ Mononucleosis
◯ Acidity/reflux	◯ Eating disorder	◯ Motion sickness
◯ ADD/ADHD	◯ Eye trouble	◯ Palpitations (heart)
◯ Anemia	◯ Fainting spells	◯ Polio
◯ Anorexia	◯ Gallbladder trouble	◯ Rheumatic fever
◯ Anxiety	◯ Head injury w/ unconsciousness	◯ Rubella
◯ Arthritis	◯ Heart murmur	◯ Seizures/epilepsy
◯ Asthma	◯ Heavy bleeding (women)	◯ Sensitivity to spices/food additives
◯ Back problems	◯ Hepatitis	◯ Sinusitis
◯ Bronchial congestion or sensitivity	◯ High blood pressure	◯ Stomach or intestinal trouble
◯ Bulimia	◯ High cholesterol	◯ Throat infections
◯ Chicken pox	◯ HIV/AIDS	◯ Thyroid problems
◯ Chronic constipation	◯ Insomnia	◯ Tuberculosis
◯ Concussion(s)	◯ Kidney infection/disease	◯ Tumor/cancer
◯ COVID-19	◯ Lyme disease	◯ Urine/bladder infection
◯ Depression	◯ Malaria	◯ Other _____
◯ Disease/injury of joints	◯ Measles	_____
◯ Diabetes	◯ Migraines	

List all medications – and dosage – you are currently taking, including any prescription medications, herbal compounds, birth control pills, and over-the-counter medications.

_____

_____

ALLERGIES **Please list and describe any allergies:**

To medications: ❒ Yes ❒ No If yes, please specify: _____

To insect bites: ❒ Yes ❒ No If yes, please specify:_____

To foods: ❒ Yes ❒ No If yes, please specify:_____

Other: _____

_____

If you answered "yes" to any of the allergies above, please describe your reaction and recommended course of prescribed action.

_____

_____

1. **Do you have special, restricted or medically prescribed diet?** ❒ Yes ❒ No

If yes, please explain: _____

_____

2. **SURGERIES**

Have you had any surgeries?

type: _____ **date:** _____

type: _____ **date:** _____

type: _____ **date:** _____

3. **Have you any significant chronic medical conditions requiring on-going medical supervision and treatment, or have you had in the past any significant chronic medical conditions which are currently in remission?**

_____

_____

_____

4. **Have you been placed on social or disciplinary probation for an incident in which alcohol or drugs were involved?** ❒ Yes ❒ No **If yes, please explain:**

_____

_____

Return completed form to your faculty leader