SUU Learning Abroad

MEDICAL INFORMATION FORM

PERSONAL INFORMATION

Full Name :

Date Of Birth : _____/_____/_____

Address : _____

Phone Number : _____ **E-Mail** : _____

EMERGENCY CONTACT DETAILS

Contact Name : _____ **Home Number** : _____

Relationship : _____ **Mobile Number** : _____

INTERNATIONAL TRAVEL AND TREATMENT

SUU requires all travelers to have international insurance coverage through CISI for the duration of their SUU travel. Do you have CISI coverage?

☐ **Attach a copy of your proof of insurance here. CISI insurance coverage can be purchased using this link:**

- https://www.mycisi.com/CISIPortalWeb/pub/SelfEnrollment.aspx?sponsor=SUTU-SE
- Those traveling to Spain will need to use this link instead: https://www.mycisi.com/CISIPortalWeb/ pub/SelfEnrollment.aspx?sponsor=SUTU-SE-SPAIN

☐ **I am taking a part in a *faculty/staff-led short-term* study abroad program through *the Office of Learning Abroad.* The Office of Learning Abroad purchases CISI insurance on behalf of these travelers, so they do not need to purchase CISI insurance on their own and do not have to upload proof of insurance coverage.**

INJURIES, OPERATIONS, ILLNESSES OR PHYSICAL CONDITIONS

Do you have any injuries, operations, illnesses or physical conditions that should be disclosed to the Office of Learning abroad prior to traveling abroad?

☐ **Yes (List the conditions i.e. high blood pressure, heart disease, diabetes etc...)**

☐ **No. No medical information needs to be disclosed at this time.**

MEDICATION

Are you under a doctors' order for any medication (that should be disclosed to the Office of Learning Abroad)?

☐ **Yes (List the medications and/or needs related to the medications below)**

☐ **No. No medications need to be disclosed at this time.**

ALLERGIES

Do you have any allergies that should be disclosed prior to traveling?

☐ **Yes (List the allergies)**

☐ **No. No allergies need to be disclosed at this time.**

OTHER DISCLOSURES

Do you have any perceptual disabilities (e.g. dyslexia), emotional or mental health challenges, or other medical or health concerns that should be disclosed to the Office of Learning Abroad?

☐ **Yes (List the conditions)**

☐ **No**

STATEMENT

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I authorize the SUU Director of Learning Abroad, or his/her authorized representative, to consent on my behalf to any x-ray, examination, anesthetic, medical or surgical or dental diagnosis or treatment, and hospital care to be rendered to me under the general or special supervision and advice of any dentist, physician, or surgeon licensed to practice when the need for such treatment is immediate and when efforts to reach emergency contacts are unsuccessful.

I agree to pay all charges incurred for the treatment of illness or injury myself. I understand that I have primary responsibility for the payment of all charges, whether or not I am covered by health or medical insurance.

Name (Printed): _____ **Phone:** _____

Signature: _____ **Date:** _____

Address: _____

(Street) (City/State) (Zip Code)