



Study Abroad

Confidential Medical History & Emergency Contact Information

GENERAL INFORMATION

Name _____
Address _____ City _____ State ____ Zip _____
Phone Number _____ Email _____
Date of Birth ____/____/____ Age ____ Male _____ Female _____ Height _____ Weight _____

PERSON TO NOTIFY IN CASE OF ILLNESS OR INJURY

Name _____ Relationship _____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Work phone _____
Email _____

INSURANCE

Travel Insurance: Austin College students studying abroad during January Term are required to have medical, medical evacuation and repatriation coverage while out-of-the-country. Austin College has arranged for group coverage through FrontierMEDEX. The cost of the coverage has been included in the total course fee billed to the student.

MEDICAL INFORMATION

If you have any health problems that we should be aware of, please check below and describe:

- | | |
|--|---|
| _____ neck, back or shoulder pain or injury | _____ diabetes |
| _____ frequent or unexplained fainting/dizziness | _____ chronic illness or physical infirmity |
| _____ vision or hearing impairments | _____ asthma, allergies or breathing difficulties |
| _____ high blood pressure and/or heart problems | _____ hypoglycemia |
| _____ known allergy to bee stings | _____ seizures |

Other _____

MEDICATIONS

Do you carry epinephrine? _____ Do you carry insulin? _____

Are you currently taking medications? Y _____ N _____

If yes, please indicate name, amount, and condition for which they are used:

Are you allergic to any medications? _____

Physician's Name _____ **Telephone** _____

Specialty _____ Other _____

By signing this form, I give permission for any emergency medical care provided by ambulance/hospital personnel that might become necessary.

Printed Name _____ Signature _____ Date _____

Parent/Guardian Name _____ Signature _____ Date _____

(If Participant is under 18)