HEALTH, INSURANCE AND EMERGENCY INFORMATION FORM

Please initial each page. _____1

Participant name_____ SCC ID #_____

I. Health

Are you currently receiving any medical or psychological care?

Yes*_____ No _____

If yes, please explain. Please note that this information will be shared with our on-site coordinator.

_____

_____

_____

_____

Is there anything in your medical/psychological history about which we should be aware (or which may affect your participation in this study abroad program? (For example: need allergy shots, chronic condition of some kind, etc.).

Yes* _____ No _____

_____

_____

_____

_____

I have consulted with a medical doctor with regard to my personal medical needs. By signing below, I certify that there are no health-related reasons or problems which preclude my participation in the Program.

I hereby acknowledge that I am physically fit and able to participate in the Program. I further agree to notify the Program staff of any health concerns that may arise before and/or during the Program.

I further acknowledge the right of Stanly Community College (SCC) to terminate my participation in the Program if health concerns warrant such action.

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*__OPTIONAL:__ Are you vaccinated against COVID-19?

- ✓ Yes
- ✓ No

*Please include a picture or a copy of your COVID-19 vaccine card.

II. Emergency Contact Information

Please provide the name and contact information of at least one person we may contact in the case of an emergency. It is the student's responsibility to update this information if it becomes necessary. I acknowledge and understand that, although I am an adult, I have been advised to discuss this trip with my parents/spouse/family and to share with them any materials or information about the elements of risk associated with this trip that I may receive. In the event I am involved in a health or safety emergency situation during my participation in the Program, I hereby authorize SCC, its representatives, employees and/or agents to notify the following person(s):

Name

_____ _____

Relationship

_____

Address

_____

Home Telephone, Work, Cell Telephone and E-mail address

_____ _____ _____

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Additional Contact:

_____ _____

Name Relationship

_____

Address

_____ _____ _____

Home Telephone Work or Cell Telephone E-mail address

_____

III. Medical Insurance

Participants cannot participate in the Program without proof of international travel insurance coverage.
I acknowledge that I have obtained and read the complimentary iNext medical-travel insurance policy approved by SCC that covers medical care and emergency care received while traveling abroad.

Print Name

_____ _____

Signature: _____

Date: _____