



**RATIONALE and PROCESS:**

Because of the stresses of overseas travel and potential health risks associated with participation in off-campus studies, it is vital for our directors to have access to the information collected on this form as they strive to protect the health and safety of the individual as well as that of other members of the group. This form will be reviewed by the director as well as by the staff of the Houghton College Health Center. Upon review, should it be determined that your health cannot withstand the rigors of the off-campus opportunity of choice, your acceptance may be rescinded. The form will be retained by the director and/or OCS office for reference during the program.

**Non-Houghton students** are required to authorize their school's health center to forward their Confidential Medical Report and Immunization Record to: Houghton College Health Center, Houghton College, Houghton, NY 14744.

**PRIVACY RELEASE: Your signature below indicates agreement to the following:**

The preceding information is correct to the best of my knowledge. Further, I understand that withholding medical information could result in my dismissal from the program, and authorize members of the health center staff to share with the OCS office any additional medical or mental health information from my health center record that they feel would be important for program personnel to know. In addition, I am willing to submit to on-site regulations regarding health practices, preventive or emergency medications. I am willing to be treated by local health officials and am willing for others to decide on the need for medical evacuation in the event of an emergency. I give my permission for any and all personal information to be shared with any of the above people.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_  
(required if participant is under 18 years old)

**INSURANCE INFORMATION: Please provide the following insurance information...**

Family Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to you \_\_\_\_\_

Subscriber ID # \_\_\_\_\_ Insurance Group Number \_\_\_\_\_

NOTE: Your primary insurance while abroad is still your family or coverage required by Houghton College. In addition you are covered by the ISIC foreign travel insurance plan (see flyer) and will be issued an ID card. In the event of needing medical treatment, you will most likely need to pay up front. Keep receipts to submit first, to your primary coverage, and then submit claims to the ISIC plan. The exception would be medical evacuation.

**EMERGENCY CONTACT INFORMATION: Please provide information for two individuals who can serve as emergency contacts...****FIRST CONTACT:**

Name: \_\_\_\_\_ Relation to you \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_ Email: \_\_\_\_\_

**SECONDARY CONTACT:**

Name: \_\_\_\_\_ Relation to you \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary phone: \_\_\_\_\_ Alternate phone: \_\_\_\_\_ Email: \_\_\_\_\_

**HEALTH CENTER REVIEW: FOR OFFICE USE ONLY**

Comments:

Staff Initials: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_