

6. Person to notify in case of emergency, illness or accident:

Name: _____ Relationship to student: _____
Street/Apt #: _____ Daytime Telephone #: (____) _____
City, State, ZIP: _____ Evening Telephone #: (____) _____
E-mail Address: _____ Cell Telephone #: (____) _____

Second person in the event that the above cannot be reached:

Name: _____ Relationship to student: _____
Street/Apt #: _____ Daytime Telephone #: (____) _____
City, State, ZIP: _____ Evening Telephone #: (____) _____
E-mail Address: _____ Cell Telephone #: (____) _____

Student Declaration

I grant the State University of New York, its employees, agents and overseas partners permission to share information concerning my health condition with program representatives, my family, insurance company representatives and with any physician, psychologist or counselor who treated me during the past five years or is now treating me. In situations where I am unable to give oral or written consent, I grant permission for hospitalization and treatment recommended and carried out under the supervision of a qualified physician, including administering anesthetics and performing necessary surgery at my own expense. I appoint the representative of SUNY in the host country for the program to act on my behalf in authorizing necessary medical, dental or surgical care, hospitalization or medical evacuation for me should this be required.

I certify that all responses made on this form are true and accurate, and that **I will notify the Administering Campus hereafter of any relevant changes in my health that occur prior to the start of the program.**

Student's Signature

Date

Parent/Guardian's Signature (required if student is under 18 years of age)

Date

***If you answered yes to 1, or 4, or no to 2 please make an appointment with your health care provider to review your medical history and travel plans and have him/her sign below.**

To the Treating Clinician: Please review the student's medical history, discuss with him/her the upcoming overseas study plans and sign below. A physical exam is not required by SUNY if you have adequate information to advise the student.

I have reviewed this student's medical history and examination with him/her, consulted with him/her about vaccinations and medications that may be required, and developed a treatment plan for the student to manage his/her condition during the overseas program, if needed. (Attach pages as necessary.)

Signature of Provider

Printed Name of Provider

Address and Phone Number of Provider

RETURN TO SUNY POTSDAM, INTERNATIONAL EDUCATION & PROGRAMS, CRUMB LIBRARY 107, 44 PIERREPONT AVENUE, POTSDAM, NY 13676 or by email attachment to international@potdam.edu or by fax 315-267-2811.