Framingham State University

EMERGENCY CONTACTS, HEALTH and INSURANCE QUESTIONNAIRE

It is essential for Framingham State University to have your current health information in case of an emergency. Please inform your program director and the Office of International Education of any changes in your health prior to and during participation in the program, including any prescription and non-prescription medications you may be taking. Please read these forms and follow all instructions for completion. Full disclosure is required. The information on these forms will assist health care providers in the event of a medical emergency. It is very important that all sections are completed fully and accurately.

This information will not affect your eligibility to participate in the program, but will help to facilitate any necessary accommodations for your participation. All information provided is private and confidential, only to be reviewed by FSU employees or representatives with a legitimate educational or safety need to know.

This information will travel with your program director in case a medical or psychological emergency arises and the information is required. The information will also be kept in the FSU Office of International Education for the duration of the program in case it needs to be used in the event of a health issue. These forms will be destroyed upon completion of your program.

Student Contact Information

Name: _____ Student ID #: _____

Date of Birth:_____ Program: _____

Home Address: _____

City: _____State:_____ Zip code: _____

Mailing Address: □ Same or _____

City: _____State:_____ Zip code: _____

Phone: □ Cell □ Home □ Other _____

Alternate Phone: □ Cell □ Home □ Other _____

First Emergency Contact:

Name: _____ Relationship: _____

Address: _____

City: _____State:_____ Zip code: _____

Phone: □ Cell □ Home □ Other _____

Alternate Phone: □ Cell □ Home □ Other _____

Second Emergency Contact:

Name: _____ Relationship: _____

Address: _____

City: _____State:_____ Zip code: _____

Phone: □ Cell □ Home □ Other _____

Alternate Phone: □ Cell □ Home □ Other _____

Student Health Questionnaire

Name: _____ Student ID #: _____

Age: _____ Height: _____ Weight: _____ Blood Type: _____

Please list any dietary restrictions: _____

Please list any allergies (insects, food, medication, etc.): _____

_____

Please list all medications you are currently taking (prescription and non-prescription (including aspirin, allergy medication, etc.): _____

_____

Please list any recent injuries or illness: _____

_____

Are you currently being treated for any physical or psychological problems that you think might impact your ability to fully participate in this program? _____

_____

Please list any other concerns that might require accommodation or would be helpful for the program staff to be aware of during your study abroad experience: _____

_____

Name of Physician: _____ Phone: _____

If a medical emergency occurs in route to or from or while I am participating in the FSU Program and I am rendered unconscious or incoherent, and my emergency contact (listed on my study abroad application) cannot readily be reached, FSU may select any licensed physician to secure and administer medical treatment, including hospitalization and surgery for me if and as needed.

I understand any medical expense so incurred will be my financial responsibility. I further release FSU and its trustees, officers, employees and agents, the Massachusetts Board of Higher Education and its trustees, officers, employees and agents, and the Commonwealth of Massachusetts from any liability in case of accident or injury.

I have carefully read and completed this questionnaire. I have listed above all the information concerning allergies, unusual medical history or conditions, dietary restrictions and regular medication that I may take.

Student Signature: _____

Printed Name: _____ Date: _____

Study Abroad Insurance Questionnaire

Name: _____ Student ID #: _____

Insurance Company: _____ Policy Number: _____

Date of Birth: _____ Dates of Coverage: _____

Program: _____ Policy Holder: _____

Do you have major medical coverage through the policy above that is valid abroad? □ Yes □ No

Are there any restrictions/limitations on procedures or providers that may be used abroad? □ Yes □ No

Are there any other restrictions on coverage abroad, such as high-risk sports injuries, pre-existing conditions or additional deductibles or co-pays? □ Yes □ No

If Yes, please identify: _____

Are you covered by insurance should you operate any kind of motor vehicle while abroad? □ Yes □ No

Does the policy include a prescription benefit, and is that benefit valid abroad? (Please note that many prescription brand names covered in the US may not be available abroad. We encourage you to find out how much coverage is available for "non-preferred" brand name medications) □ Yes □ No

Do you have legal or liability coverage that will cover you abroad (either through your health insurance or other insurance policy)? □ Yes □ No

If Yes, please identify: _____

Please review your answers to the questions above. If you are concerned that you do not have adequate insurance coverage while you are abroad, please contact the Office of International Education for information on finding adequate coverage. Please also be sure that your coverage in the United State is adequate and up to date.

FSU requires that any person participating on a faculty-led short term program abroad purchase emergency medical evacuation insurance, in the case of an emergency abroad in which you must be medically evacuated. The cost of this insurance is included in your Program fee.

I have carefully read and completed this questionnaire. I have adequate insurance coverage for my studies and travels abroad through the Program.

Student Signature: _____

Printed Name: _____ Date: _____

SIGNATURE OF PARENT(S) OR LEGAL GUARDIANS(S) REQUIRED IF STUDENT IS UNDER EIGHTEEN (18).

Parent(s)/Guardian(s) Signature(s): _____

Printed Name(s): _____ Date: _____