



Framingham
STATE COLLEGE

EMERGENCY CONTACTS, HEALTH, and INSURANCE QUESTIONNAIRE

It is essential for Framingham State College 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 FSC 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 FSC 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.

Name: _____

Student ID #: _____

Date of Birth: _____

Program: _____

EMERGENCY CONTACTS

HOME ADDRESS: _____

City: _____ State: _____

Zip: _____

MAILING ADDRESS: _____

City: _____ State: _____
Zip: _____
Home Phone: _____ Work Phone: _____
Other: _____

First Emergency Contact:

Name: _____
Relationship: _____
Address: _____

City: _____ State _____ Zip _____
Home phone: _____ Work: _____ Other: _____

Second Emergency Contact:

Name: _____
Relationship: _____
Address: _____

City: _____ State _____ Zip _____
Home phone: _____ Work: _____ Other: _____

HEALTH QUESTIONNAIRE

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

Please list any dietary restrictions: _____

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

Please list any medications you are currently taking (this includes non-prescription medications, such as aspirin, allergy pills, etc.): _____

Please list any recent injuries or illnesses: _____

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 student's physician: _____ Phone: _____

If a medical emergency occurs in route to or from or while I am participating in the FSC Program and I am rendered unconscious or incoherent, and my emergency contact (listed on my study abroad application) cannot readily be reached, FSC 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 FSC 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.

Signature of Student

Printed Name:

Date:

STUDY ABROAD INSURANCE QUESTIONNAIRE

Name: _____

Insurance

Company: _____

Student ID #: _____

Policy Number _____

Date of Birth: _____

Dates of coverage: _____

Program: _____

Policyholder: _____

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: _____

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). _____

Do you have legal or liability coverage that will cover you abroad (either through your health insurance or other insurance policy)? _____

Are you covered by insurance should you operate any kind of motor vehicle while abroad? _____

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.

FSC 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.

Signature of Student
Date:

Printed Name

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

Signature of Parent(s)/Guardian(s)

Printed Name

Date: