State University of New York **Upstate Medical University**	**Study Abroad Agreement and Release** **for International Programs**

Name:____
First Middle Last

College/Program:____

Location: _________________________ Dates Abroad: _________________________
Address Abroad

1. Participant pledges to conduct himself/herself in a manner that will reflect favorably on himself/herself, Upstate Medical University, the State University of New York, and the United States of America.

2. Participation in the above program is entirely voluntary, and will require transportation to and habitation in another country, and may involve risks relating to or arising out of program activities.

3. Participant understands that there are risks inherent in travel, living and study in another country, and acknowledges that s/he has been apprised of such risks (to the extent that such risks are known to SUNY), and agrees to assume all risks and responsibility for his/her health, safety, and property while participating in this program.

4. Participant releases the State University of New York, Upstate Medical University and the State of New York, their officers, trustees, employees, and agents from any and all liability, damage or claim of any nature arising out of, or in any way related to participation in this program, the transportation, or in any independent activities undertaken as an adjunct thereto.

5. Participant agrees to be responsible for any damage or liability incurred as a result of any illness or accident Participant may suffer, including the costs of any medical care not covered by insurance, or any injury or damage to any person or property of others which Participant may cause, or for any financial liability or obligation which Participant may personally incur, while participating in the program.

6. Participant understands that Upstate Medical University reserves the right to make cancellations, changes or substitutions in cases of emergency or changed conditions, or in the interest of any program-sponsored group with which the Participant may be traveling or collaborating.

7. Participant understands and agrees that all students are subject to regulations outlined in materials provided by Upstate Medical University, regulations of the host institution, and laws of the host country. In the event of violation of any of the foregoing, or any other behavior which is detrimental to the Participant, other students or the program, the director of the program shall have the right to dismiss the Participant from the program. The

8. Participant further agrees that, if expelled from the program, s/he is responsible for all expenses of the program, including return to the point of origin, and that no refund of fees will be given.

9. Participant also acknowledges and understands that, should s/he develop legal problems with any foreign nationals or government of the host country, Participant will attend to the matter personally, with his/her own personal funds. Upstate Medical University is not responsible for providing any assistance under such circumstances.

10. Participant agrees that s/he will be responsible for all medical and related expenses incurred while participating in the program. Participant is responsible for securing accident and medical insurance that meets SUNY standards.

Submission of Required Forms: Participant agrees to submit all required forms by the deadline.

Travel and Accommodation: Participant acknowledges and agrees to accept all responsibility for loss or additional expenses due to delays or other changes in the means of transportation, other services, or sickness, weather, strikes or other unforeseen causes.

Participant acknowledges and understands that the Upstate Medical University assumes no liability whatsoever for any loss, damage, destruction, theft or the like to the student's luggage or personal belongings, and certifies that Participant has retained adequate insurance or has sufficient funds to replace such belongings.

Participant acknowledges and understands that in the event that s/he becomes detached from the trip group, fails to meet a departure bus, airplane or train, or becomes sick or injured, Participant will bear all responsibility to seek out, contact and connect with the trip group at its next available destination; and that Participant shall bear all costs involved in contacting and reaching the trip group at its next available destination.

Participant is solely responsible for securing any necessary immunizations prior to departure.
All services and accommodations are subject to the laws of the country in which they are provided. Upstate Medical University in no way represents or acts as an agent for transportation carriers, hotels, and other suppliers of services connected with this program.

I have carefully read this form before signing it.

Student Signature Date

State University of New York **Upstate Medical University**	**Permission to Release Information** **for International Programs**

Under Federal regulation, Upstate Medical University is unable to release any information about you to anyone without your permission. But at times, you may want us to release information regarding health matters, travel arrangements and personal safety. If you would like us to share any information about you with an emergency contact while you are abroad, please indicate below the full names and contact information for these contacts. Please include any restrictions on the information to be shared, if any. If you do not wish to designate anyone, please indicate this at the bottom of the form.

First Contact:

Full name: ____________________________ Email address: _____________________________
Relationship:_________________________ Is this your emergency contact? (circle one) yes/no
Address:____

Phone Numbers:____
Restrictions: ____

Second Contact:

Full name: ____________________________ Email address: _____________________________
Relationship:_________________________ Is this your emergency contact? (circle one) yes/no
Address:____

Phone Numbers:____
Restrictions: ____

____ (initial) Do not release any information about me to anyone.

Name: _________________________________ ID No: ____________________________
Print

Your Signature: __________________________ Date: ______________________________

Date this release expires and is no longer valid: ____

State University of New York **Upstate Medical University**	**Physician's Statement** **for International Programs**

TO THE STUDENT: Please authorize by your signature below the release of any medical information that may be relevant in the opinion of your physician.

Name: ____
First Middle Last

Program:____
Location Abroad Length of International Program Dates

Participant Signature: ____

TO THE EXAMINING PHYSICIAN: This report should be based upon an examination made within six months of the expected international travel.

1. Please indicate your relationship with the participant.

   Family Physician University Physician Other (describe):__________

2. Review with the patient the completed Health Information form. Describe below any additional information that would help further explain and/or clarify the student's self-reported health information.

3. Based upon your physical examination, please explain your findings and recommendations.

   Physical Findings:

   Recommendations:

4. Is there any existing health condition that may require treatment during the period abroad? If so, what is the condition and what treatment may be required?

5. To your knowledge are there any predisposing medical, physical, or emotional factors which under stress of adjusting to another culture may require treatment while the patient is abroad? If so, please specify.

6. Review and update routine vaccinations as you deem necessary.

7. Has the student received the CDC recommended vaccinations for the country where they will be traveling?

Physician's Name (please print): __________________ Address: ___________________________

Physician's Signature ___________________ Date: ______________________________

State University of New York **Upstate Medical University**	**Participant Health Information** **for International Programs**

Name: ____
First Middle Last

Program:____
Location Abroad Dates

To the Student: Complete this form and review it with your physician during your physical examination. The information provided by you and your physician(s) will remain confidential.

1. Are you generally in good physical conditional? (If no, explain) Yes No

2. Have you ever been, or are you currently being treated for any psychological or emotional problems? (If yes, have your physician or counselor attach a note of explanation) Yes No

3. Do you have any other on-going emotional or physical conditions (including eating disorders) that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? (If yes, list and indicate recommended treatment) Yes No

4. Do you have any allergies, reactions to medications and/or dietary Restrictions? (If yes, explain) Yes No

5. Are you currently taking any medications? (If yes, list medications and Ailment) Yes No

6. Have you had any major injuries, diseases, or ailments in the last five years? (If yes, explain) Yes No

7. Person to notify in case of emergency, illness or accident:
   Name:_________________________ Relationship to Participant: __________________

   Street/Apt#:____________________ Phone #: _________________________________

   City, State, Zip: __________________ Email Address: ____________________________

I grant the State University of New York, its employees, agents and international partners permission to communicate concerning my health condition with program representatives, my family, insurance company representatives and with my physician, psychologist or counselor who treated me during the last five years or is now treating me. In situations where I am unable to give oral or written consent, I further 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 certify that all responses made on this form are true and accurate.

____

Student Signature Date