# State University of New York Upstate Medical University

## Study Abroad Agreement and Release for International Programs

Name:				
	First	Middle	Last	
College/Progra	m/Department:			
Location:		Dat	es Abroad:	
Δ	ddress 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 participants 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/participants 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 participant'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.

Participant Signature	Date

I have carefully read this form before signing it.

#### 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:
	Is this your emergency contact? (circle one) yes/no
Address:	
Phone Numbers:	
Restrictions:	
Second Contact:	
Full name:	Email address:
	Is this your emergency contact? (circle one) yes/no
Address:	
Phone Numbers:	
Restrictions:	
(initial) Do not release an	y information about me to anyone.
Name:	ID No:
Print	
Your Signature:	Date:
Date this release expires and is	s no longer valid:

#### State University of New York Upstate Medical University

## Physician's Statement for International Programs

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

Name	:					
	Firs	t	Middle	Last		
Progra	am:					
	Location Abro	oad	Length of Inte	rnational Program	Dates	
Partic	ipant Signature:					
	E EXAMINING PHYSICI ed international trave	•	ould be based up	oon an examination mad	e within six months of the	
1.	Please indicate you	r relationship with	the participant.			
	Family Physician	University Phys	ician	Other (describe):		
2.	· · · · · · · · · · · · · · · · · · ·	· ·		ntion form. Describe below the student's self-re	ow any additional ported health information.	
3.	Based upon your ph	nysical examination	n, please explain	your findings and recom	mendations.	
	Physical Findings:					
	Recommendations:					
4.	Is there any existing the condition and w			treatment during the pe	eriod abroad? If so, what is	
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 vaccination	ns as you deem ı	necessary.		
7.	Has the student rec traveling?	eived the CDC rec	ommended vacci	nations for the country v	vhere they will be	
Physici	an's Name (please pri	nt):	A	ddress:		
Physici	an's Signature		Date:			
Updat	ed 27 MARCH 2017					

#### **State University of New York Upstate Medical University**

#### **Participant Health Information** for International Programs

	First	Middle	l	₋ast		
Program	n: Location Abroad		Datas			
	Location Abroad		Dates			
	articipant: Complete this form an by you and your physician(s) will		ysician during	your phys	sical examination.	The information
1.	Are you generally in good physic	al conditional? (If no, ex	plain)	Yes	No	
2.	Have you ever been, or are you opsychological or emotional probor counselor attach a note of exp	lems? (If yes, have your		Yes	No	
3.	Do you have any other on-going (including eating disorders) that that might be exacerbated by th climate, diet or exercise? (If yes, treatment)	might require treatmen e stress caused by chang	t abroad, or ges in culture,	Yes	No	
4.	Do you have any allergies, reacti Restrictions? (If yes, explain)	ions to medications and,	or dietary	Yes	No	
5.	Are you currently taking any mealiment)	dications? (If yes, list me	edications and	l Yes	No	
6.	Have you had any major injuries years? (If yes, explain)	, diseases, or ailments ir	the last five	Yes	No	
7.	Person to notify in case of emerg					
	Street/Apt#:	Phone #:				
	City, State, Zip:	Email Address:				
concernion ohysician unable to out unde own expe		ram representatives, my reated me during the la rther grant permission f nysician, including admir	r family, insur- st five years o or hospitaliza histering anes	ance comp or is now tr tion and tr	pany representati reating me. In situ reatment recomm	ves and with my uations where I am nended and carried
I certify	that all responses made on this fo	orm are true and accura	te.			
Particina	ant Signature			Dat	te	