West Texas A&M University
Office of Study Abroad

MEDICAL CONSENT AND EMERGENCY CONTACT FORM

All information provided is private and confidential. Please inform the Office of Study Abroad if any changes to this form need to be made prior to departure.

Name (First, M.I., Last): _____ **Date of Birth:** _____

Program location: _____ **Dates of program:** _____

I, the undersigned participant, authorize the West Texas A&M University Study Abroad Office to use this information and their best judgment in providing necessary information to individuals procuring or providing medical attention for me in the event of a medical emergency in which I am unable to respond.

Student Signature _____ **Date:** _____

Emergency Contact: _____

Relationship to Student: _____

Address: _____

Primary Phone: _____ **Cell Phone/Other:** _____

Email Address: _____

Please answer the following health questions to the best of your knowledge. If you answer yes to any of the questions, please supply details. You may use the reverse side if necessary.

	YES	NO
1. Do you have a medical and/or emotional condition that the faculty leader should be aware of?	☐	☐
2. Are you currently taking any medications (prescription and non-prescription)?	☐	☐
3. Do you have allergies to medication, food, insects, etc.? How do you react?	☐	☐
4. Do you have special concerns or needs that may require advance arrangements?	☐	☐

State Law requires that you be informed of the following: (1) You are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law); (2) You are entitled to receive and review that information; and (3) You are entitled to have the information corrected at no charge to you.