CSUB
Off Campus Academic Program

MEDICAL DISCLOSURE and WAIVER of LIABILITY

This document should be on CSUB letterhead clearly identifying the sponsoring school and department. The document should include the program title, destination, academic quarter/year, and beginning and ending dates of the program as well as the following information. **To assure compliance with the Americans with Disabilities Act, provide the form to participants only after they have been accepted into the program.** The off campus program coordinator should hold the completed original, the department should hold a copy and a copy must be provided to the participant. **This is confidential information.**

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NAME OF
PARTICIPANT: ____

The following medical information may be necessary in the event of serious illness or accident. Please complete this form accurately and truthfully. The facts you disclose will be kept confidential and will be used only to help the staff respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness, particularly if you are unable to respond clearly to the medical staff's inquiries. Please print your responses. Attach additional pages if more space is needed.

PERSON TO CONTACT IN EVENT OF EMERGENCY (parents or nearest relative)

Name: ______________________________________ Relationship: ________________________

Phone: ______________________________________ Message Phone: ______________________

Address: ____

MEDICAL INSURANCE: Each participant must have medical/accident insurance that will cover the expenses of serious illness or accident, as well as accidental death and dismemberment coverage, emergency evacuation, and repatriation of remains. For foreign travel programs, insurance must be obtained through the California State University's Study Abroad Health Insurance Program. Domestic programs require proof of health insurance that meets or exceeds the CSU Domestic Student Health Insurance Plan. You must check with your health plan to verify that coverage applies and service providers are available in the region you are going to.

List below your medical/accident insurance company and policy #:

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REIMBURSEMENT OF MEDICAL/ACCIDENT EXPENSES: In the event of serious illness, accident, emergency evacuation to a medical facility, or repatriation of remains, all expenses must be paid at the time of treatment or activity. Insurance carriers provide reimbursement upon documentation of a covered claim.

Participants are responsible for all expenses in the event that they become ill, injured, or require emergency evacuation.

PHYSICAL CONDITION: Please list all physical disabilities, chronic illnesses, allergies, previous injuries or any other limitations that could affect your full participation in this program.

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DIETARY RESTRICTIONS: Please describe any dietary restrictions

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MEDICATIONS: List all medications you will be taking during this program. Bring sufficient quantities of required medications AND the prescription should you need an additional amount. All medicines, prescribed or over-the-counter, must be transported in their original packaging.

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Health and Safety Certification

I have consulted with a medical doctor with regard to my personal medical needs. I am aware of all applicable personal medical needs. There are no health related reasons or problems that preclude or restrict my participation in this program.

The University may, but is not obligated to, take any actions it considers to be warranted under the circumstances regarding my health and safety. I agree to pay all expenses relating thereto and release the University for any liability for any actions.

In the event that I am physically incapable of consenting to medical attention, I place within the discretion of the Program Director, or person designated by him/her, the decision to seek and allow professional medical attention or service performed by any medical officer licensed under the laws of whatever state or nation I find myself during the period of the travel study program.

I assume all risk and responsibility for my own medical needs. I hereby waive all claims or causes of action against the State of California, the Trustees of the California State University, California State University Bakersfield, its auxiliary organizations, and the officers, directors, employees and agents for responsibility for any health problems incurred during my participation in the above referenced travel program.

I acknowledge that I have received a complete copy of his medical waiver form.

Participant's Signature Printed Name Date

Parent/Guardian signature if participant is a minor Printed Name Date

(A signed authorization for medical treatment of a minor must be attached.)