

Participant Vital Data Form and Emergency Information

One copy to be kept on-site with program director and one copy to be forwarded to the office of the VPAA.

You are applying for the Snow College Student Travel Program. This program includes travel to foreign countries with terrain different from that found in the U.S. for example: unpaved roads, cobblestone, stairs, and other obstacles. A certain level of physical fitness may be required to navigate these different obstacles as well as the extensive walking that may be required. While Studying Abroad you may also experience homesickness, culture shock, and other stresses that come from traveling outside of the United States. These stresses may cause acute physical, psychological, or emotional issues to become more of a concern.

We encourage you to get a physical examination to determine your level of fitness and if the program is a good fit for you.

We urge you to fill out following information with as much detail as possible so that your Program Director can better understand your unique situation and so that we at the Study Abroad Program can better plan for incidents or help in the event of an emergency.

This document and the information provided will be confidential and will only be shared with program staff, faculty, and health providers abroad only if vital to your personal health. The information provided on this document will not affect your application unless your physical or mental health condition will prevent your successful participation in the program.

Name:	First	Middle	Last
Address:			
Home Phone:		Cell Phone:	
Passport Number:		Place of Issue:	
Date of Issue:		Date of Expiration: ____/____/____	

EMERGENCY CONTACT INFORMATION

Name:	Relationship:
Address:	
Home Phone:	Work Phone:

MEDICAL INFORMATION

Please list any medical conditions the program director should be aware of:	
Allergies:	
Drug Prescriptions:	
Blood Type (if known):	
US Health Insurance Carrier:	
ID or Group Number:	Phone:

I affirm it is my responsibility, together with my physician, to determine if I am in a good enough condition to participate in the Student Travel Program. To the extent I have chosen to disclose information, I certify that all responses made on this form are true and accurate to the best of my knowledge.

Participant's Name (print)

Participant's signature

Date