

**Medical Information  
Emergency Contact  
Study Abroad Program**

**Program Information**

Study Abroad Program: \_\_\_\_\_

Classes enrolled in the study Abroad Program: \_\_\_\_\_

Language proficient in:           1. \_\_\_\_\_ Speak ( ) Read ( ) Write ( )  
  2. \_\_\_\_\_ Speak ( ) Read ( ) Write ( )

**Personal Information**

Name: \_\_\_\_\_ Gender: Male ( ) Female ( )

Address: \_\_\_\_\_

Student ID #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Cell#: \_\_\_\_\_ Passport# \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_

Class Level (Circle one):       Freshman   Sophomore   Junior   Senior   Graduate

**Medical Information**

This Medical Information form will be used in case of an emergency during the trip. Please submit one signed and dated copy. One copy will be kept in the CSUSB Study Abroad Office and a second copy with will be kept by the Faculty Supervisor.

Physician's Name: \_\_\_\_\_

Physician's Contact Information: \_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Language spoken by the person: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell#: \_\_\_\_\_ Email: \_\_\_\_\_

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

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2. Do you have any allergies to foods, medications, environmental factors, insects, etc.? Yes  No  If yes, please explain what happens when you come in contact with the allergen? How do you usually treat this reaction?

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3. Are you taking any medication(s)? Yes  No  If yes, students are responsible to bring enough medication to last through the trip.

4. Is there any health information that would be helpful to the faculty and/or host families to be aware of during the study abroad program? If yes, please describe.

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5. Is there anything a health care professional needs to know in order to treat you in an emergency situation? If so, please explain.

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6. Do you know your blood type? Please state: \_\_\_\_\_

I certify that all responses made on this Medical Fitness Statement are true and accurate. I will notify the Study Abroad Office of any relevant changes in my health that occur prior to the start of the program. I understand that this form is for information purposes only and in no way implies that California State University, San Bernardino, takes responsibility for my health. I understand my information will be kept confidential.

Signature:

Date: