

*Please type or print.*

Name: \_\_\_\_\_  
Last First Middle

Program: \_\_\_\_\_  
Location Abroad Term Abroad

**To the Student:** As with all academic programs, certain conditions must be adhered to in order to preserve program integrity. As a necessary precaution to protect the State of New York, the State University of New York and the **College at Oneonta**, these conditions are listed below. We ask that you **read carefully** and **indicate with your signature that you understand them and will comply**. If you are a participant under the age of 18, your parent or guardian's signature is also required.

1. Participant pledges to conduct himself/herself in a manner that will reflect favorably on himself/herself, his/her home campus, the **College at Oneonta**, 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 residence 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, the **College at Oneonta** 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 the **College at Oneonta** 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 students are subject to regulations outlined in materials provided by the **College at Oneonta**, 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 or the program, the director of the program shall have the right to dismiss the Participant from the program. The 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.
8. 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. The **College at Oneonta** is not responsible for providing any assistance under such circumstances.
9. 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.

10. Participant agrees to report to the **College at Oneonta** Office of International Education at least 60 days prior to the start of the program any physical or mental condition that may require special medical attention or accommodation while participating in the program.

**Other Conditions of Participation**

**Participation:** Participant agrees to participate fully in all portions of the program and further agrees that any deviation from the program design must be requested in advance and in writing by Participant and must be approved by the **College at Oneonta** Office of International Education or the program director.

**Payment Deadline(s):** Participant and his/her parent/guardian are aware of the nature and the cost of the program and will guarantee that all financial obligations will be met by the deadline(s) specified on the bill statement. Financial aid recipients will submit all documentation required by their home campus's Financial Aid Office and will either remit any balance owing by the payment deadline(s) or arrange for a deferment through the **College at Oneonta** Office of International Education prior to the payment deadline.

**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 **College at Oneonta** assumes no liability whatsoever for any loss, damage, destruction, theft or the like to the student'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.

The **College at Oneonta** in no way represents or acts as an agent for transportation carriers, hotels, and other suppliers of services connected with this program.

**Refunds for Program Withdrawal:** Refunds for voluntary withdrawal from the program are subject to the official withdrawal policies of the **College at Oneonta**. Participant acknowledges that any refund of program fees will be based on monies that may be recoverable at the time of withdrawal. If Participant has not paid his/her program fees in full, s/he will be liable for any outstanding balance still owed once liability for program fees has been adjusted.

***I have carefully read this form before signing it.***

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Student's Signature

Date

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Parent/Guardian's Signature (required if student is under 18 years of age)

Date

**STATE UNIVERSITY OF NEW YORK**  
**Overseas Academic Programs**

**PROOF OF INSURANCE**  
**STUDY ABROAD**

*Please type or print.*

Name: \_\_\_\_\_  
Last First Middle

Program: \_\_\_\_\_  
Location Abroad Administering Campus

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Citizenship: \_\_\_\_\_  
Mo/Day/Yr

Date of Departure: \_\_\_\_\_ Date of Return: \_\_\_\_\_  
Mo/Day/Yr Mo/Day/Yr

Health and accident insurance is **required** of all State University of New York study abroad program participants. We strongly advise a policy that is designed especially for students studying abroad. Such a policy should minimally include basic medical and accidental death and dismemberment coverage. Medical evacuation and repatriation coverage is also required. The coverage must be in effect for the entire period away from home. Those who do not have such coverage must purchase the insurance provided by SUNY. Complete descriptions of the SUNY International Student and Scholar Health Insurance Plan and the MEDEX Medical Evacuation and Repatriation Rider are enclosed.

Please select one of the following options:

A. \_\_\_\_\_ I wish to waive the SUNY International Student and Scholar Health Insurance Plan because I have comparable insurance coverage. I will purchase the MEDEX Medical Evacuation and Repatriation Rider from SUNY. I understand that if my medical insurance is found not to meet SUNY requirements, I will be required to purchase the appropriate SUNY coverage.

\_\_\_\_\_ I have attached documentation from the company that I will be adequately covered while abroad and that payment of claims can be made.

\_\_\_\_\_ I have attached a copy of the front and back of the insurance card, showing the name of the covered student.

\_\_\_\_\_ I have signed the Insurance Waiver Form.

B. \_\_\_\_\_ I wish to purchase the SUNY International Student and Scholar Health Insurance Plan (which includes the MEDEX Medical Evacuation and Repatriation Rider).

\_\_\_\_\_  
Student's Signature Date

\_\_\_\_\_  
Parent/Guardian's Signature (required if student is under 18 years of age) Date

# STATE UNIVERSITY OF NEW YORK Overseas Academic Programs

# STUDENT HEALTH INFORMATION

*Please type or print.*

Name: \_\_\_\_\_  
Last First Middle

Program: \_\_\_\_\_  
Location Abroad Administering Campus

**To the Student:** Complete this form and review it with your physician during your physical examination. The information provided by you and your physician(s) will remain confidential.

1. Are you in generally good physical condition? (If no, explain)  Yes  No
2. Have you ever been, or are you currently being treated for any psychological or emotional problems? (If yes, have your physician or counselor attach a note of explanation)  Yes  No
3. Do you have any other on-going emotional or physical conditions (including eating disorders) that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? (If yes, list and indicate recommended treatment)  Yes  No
4. Do you have any allergies, reactions to medications and/or dietary restrictions? (If yes, explain)  Yes  No
5. Are you currently taking any medications? (If yes, list medication name and ailment)  Yes  No
6. Have you had any major injuries, diseases, or ailments in the last five years? (If yes, explain)  Yes  No
7. (*Disclosure of disabilities is optional*). Do you have a disability for which you are seeking accommodations? If yes, please provide a description of desired accommodations. Please be aware that the Americans with Disabilities Act (ADA) does not apply outside the borders of the U.S. However, the Administering Campus will assist you, to the extent possible, to obtain the accommodations you may want. We may not be able to obtain the accommodations necessary to enable you to participate in all aspects of the overseas program.  Yes  No

8. Person to notify in case of emergency, illness or accident:

Name: _____	Relationship to student: _____
Street/Apt #: _____	Daytime Telephone #: (____)_____
City, State, ZIP: _____	Evening Telephone #: (____)_____
E-mail Address: _____	Cell Telephone #: (____)_____

I grant the State University of New York, its employees, agents and overseas partners permission to communicate concerning my health condition with program representatives, my family, insurance company representatives and with any physician, psychologist or counselor who treated me during the past five years or is now treating me. In situations where I am unable to give oral or written consent, I further grant permission for hospitalization and treatment recommended and carried out under the supervision of a qualified physician, including administering anesthetics and performing necessary surgery at my own expense. I further appoint the representative of SUNY in the host country for the program to act on my behalf in authorizing necessary medical, dental or surgical care, hospitalization or medical evacuation for me should this be required.

I certify that all responses made on this form are true and accurate, and that **I will notify the Administering Campus hereafter of any relevant changes in my health that occur prior to the start of the program.**

\_\_\_\_\_  
Student's Signature Date

\_\_\_\_\_  
Parent/Guardian's Signature (required if student is under 18 years of age) Date

**STATE UNIVERSITY OF NEW YORK**  
**Overseas Academic Programs**

**PHYSICIAN'S STATEMENT**

**TO THE STUDENT:** Please authorize by your signature below the release of any medical information that may be relevant in the opinion of your physician to your participation in a study abroad program.

Name: \_\_\_\_\_  
Last First Middle

Program: \_\_\_\_\_  
Location Abroad Length of Overseas Program Dates of Participation

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature (required if student is under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_

**TO THE EXAMINING PHYSICIAN:** The above named student has been accepted to participate in a State University of New York Overseas Academic Program. S/he will live and study for a summer, semester or year in the country/countries noted above. This report should be based upon an examination made within six months of the expected overseas program participation.

1. Please indicate your relationship with the student. (Note: Parent-physician reports are not acceptable.)

Family Physician       College/University Physician       Other (describe): \_\_\_\_\_

2. Review with the student the Student Health Information form s/he completed. Please describe below any additional information that would help to further explain and/or clarify the student's self-reported health information.

3. Based upon your physical examination of this student, please explain your findings and recommendations.

Physical Findings:

Recommendations:

4. Is the student allergic to any medications? If so, please list:

5. Is there any existing health condition that may require treatment during the period of study abroad? If so, what is the condition and what treatment may be required?

6. 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 student is abroad? If so, please specify.

7. Review and update routine vaccinations as you deem necessary.

Physician's Name (please print): \_\_\_\_\_ Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_