

**Hobart and William Smith Colleges
Domestic Programs Off-campus
Medical Profile and Information Form**

Students: Please note that this document is intended solely for the use of the Center for Global Education and the Faculty Directors of your program. The information will be used only to provide for your care and to otherwise assist you in the event of a problem while you are away. Please provide as much detail as possible so we may be fully aware of any medical conditions you may have, medications you are taking, etc.

Name: _____ Program and semester: _____

Cell Phone: _____ E-Mail: _____

Home Address: _____

Date of Birth: _____ Gender: M / F

In Case of Emergency Notify:

1. Name _____ Relationship to you: _____

Address: _____

Home phone: _____ E-Mail: _____

Cell phone: _____ Work phone: _____

Other Information:

Known allergies or drug reactions: _____
(Please describe type and severity of reaction)

Current Medications: _____
(please provide the name of the medication, the dosage you are taking and the reason for the medication)

Current medical problems or health concerns:

Past illnesses we should be aware of: _____

Dietary restrictions: _____

Do you have any handicap or disability which will require accommodation? (Include academic accommodations) ___ yes ___ no

If yes, please list: _____

Is there any other information we should know about you? _____

I give permission for this form to be kept on file with the Center for Global Education and with the faculty directors of my program and for the form to be provided to health care personnel in the event that I require medical care during my semester off campus.

In the event that I am unable to give consent to medical care myself in the case of a life-threatening emergency, and/or if my parents/guardians cannot be reached, I hereby give to the faculty directors or a duly appointed representative consent to care for me, including medical and surgical treatment and hospitalization if necessary.

Signature: _____

Date: _____

For travelers under 18 years of age:

I give permission for the faculty director(s) or his/her representative to obtain and consent to care for my son/daughter, including medical and surgical treatment and hospitalization if necessary, in the event that I cannot be reached in an emergency.

Signature of parent/guardian: _____

Date: _____

(only required if you are under 18)

Phone: _____