TRINITY INTERNATIONAL UNIVERSITY
FORM 700-H
Health Information and Release Form

This form is meant to assist Trinity International University and its program directors in helping you should a health need arise during your off-campus program. It is important for you to make the program director(s) aware of any medical or emotional problems that arise during an off-campus program. The information you provide below will remain confidential and will be shared only with program staff or appropriate professionals, and then only if pertinent to your well-being.

I. Program Title: ____Dates of Travel__________________________

II. Participant Information:

Participant Name ____ Birth Date: ________________________
(Please print)

Current Status: ______ Undergraduate Student _______ Graduate Student ______Trinity Faculty/Staff
______ Volunteer Leader _______ Alumnus/Alumna ______Other:____________________________

For Students: Campus Box# ______________ Telephone number: ______________________ Student ID#: ___________________

Permanent Address ____________________________________ _____________________ ______________ ____________
Street City State/Country Zip code

Emergency Contact ____ ___________________________________
Name Relationship to Participant

______________________________ ______________________________ ______________________________
Daytime phone Evening Phone Cell Phone

Do you have any physical or medical conditions that we need to be aware of in the event of a medical emergency? _______ (Yes or No)

What medications will you be taking while on this trip and for what condition have they been prescribed? _______________________

____

Do you have allergic reactions to any of the following? Check all that apply:
____Aspirin ____Bee sting ____Codeine ____Penicillin ____Sulfa Drugs ____ Other: ____________________

III. Medical/Hospitalization Insurance Coverage Information:

To participate in this program, you must be covered by a health insurance policy. Please check all that apply:
____I have coverage through my parents' health insurance.
____I have coverage through a personal health insurance policy.

NOTE: Be sure the policy covers the location(s) where you will be traveling (e.g. outside your state or outside the continental U.S.). Also, please be aware of any policy restrictions (e.g. limits of coverage, excluded countries, excluded injuries, etc.).

Name of Insurance Company:____

Policy number: _______________________________ Dates coverage is provided: From: ___/___/___ to ___/___/___.

IV. Vaccinations:

I understand I may visit countries, destinations or areas where definite and significant biomedical hazards exist. These hazards may include, but are not limited to, infectious, tropical, parasitic and other diseases, viruses or bacteria; contaminated water or food, and insect, spider, snake, fish or animal bites.

Trinity International University cannot recommend precautions for each individual. Therefore, I acknowledge _________(participant's initials) that it is my responsibility to consult a health care practitioner of my choice in order to become familiar with the biomedical hazards that I may encounter during the Program, and to obtain the appropriate prescription of medications.

V. Signature: I certify that all the responses made on this Health Information form are true and accurate. Additionally, I will notify the program director of any relevant changes in my health that occur either prior to, or during, the program event. I further verify that:

a) I have no current medical condition that might put others or myself in danger by my participation in this program.
b) I will abide by all Trinity International University regulations and other applicable regulations regarding my participation.
c) If I become injured in the course of my participation and am unable to seek treatment for myself, I hereby give permission for emergency medical treatment to be sought for me by representatives acting on behalf of Trinity International University.

____ ______________________________
Signature of Participant Date Signed

____ _______________________________
Signature of Parent/Guardian if Participant is under 18 Date Signed

Last Revised 7/2015