

EMERGENCY CONTACT & TREATMENT PERMISSION

On rare occasion, an emergency requiring hospitalization and/or surgery may develop. This form is intended to prevent dangerous delay in treatment in case of emergency.

Name: _____

Destination: _____

Term Abroad: Summer 20__ Fall 20__ Spring 20__ Full Academic Year 20__ - 20__

Emergency Contact #1	Emergency Contact #2
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____ _____ _____	Address: _____ _____ _____
Phone numbers Work: _____ Home: _____ Cell: _____	Phone numbers Work: _____ Home: _____ Cell: _____
E-mail: _____	E-mail: _____

1. I am insured under:

Policy Number _____

Company Name _____

Expiration Date _____

2. Medicines I am allergic to:

3. The following are medical conditions which a physician in another country or state should be aware of:

In the event of an emergency I give permission for a representative of the host institution to authorize treatment or hospital care, which in the best judgment of a licensed health care professional, is deemed advisable.

Signature of Student _____

Date _____

Signature of Parent _____
(Or legal guardian if applicable)

Date _____

NOTE:

Make at least three (3) copies of this form:

**1 for yourself to carry with your passport
1 for your TCNJ study abroad application
1 for host institution**