NOSTOS Program
Medical Information Release Form

PERSONAL DETAILS

(The name you give on your application should correspond exactly with that written on all official documents which you will be required to produce as evidence of identity).

FIRST NAME	
LAST NAME	
FATHER'S NAME	
MOTHER'S NAME	
GENDER	
DATE OF BIRTH *(DD/MM/YYYY)*	
NATIONALITY *(as written in your passport)*	
PASSPORT or ID NUMBER	

CONTACT DETAILS

HOME ADDRESS	Address:
	City:
	Province/County:
	State:
	Zip Code (or Postal Code):
	Country:
E-MAIL ADDRESS *(please, fill in an e-mail address where you may be contacted at any time)*	
PHONE NUMBER *(please, include international and area codes)*	
MOBILE PHONE NUMBER	

EMERGENCY CONTACT DETAILS

FIRST/LAST NAME	
HOME ADDRESS	Address:
	City:
	Province/County:
	State:
	Zip Code (or Postal Code):
	Country:
E-MAIL ADDRESS	
PHONE NUMBER *(please, include international and area codes)*	
MOBILE PHONE NUMBER	

MEDICAL INFORMATION FORM

Instructions: It is important to the success of your experience abroad that your host program/institution be aware of your health-related needs and/or concerns. We encourage you to be proactive about health concerns while abroad by discussing them early on with a health or disability counselor on campus and with the on-campus coordinator. Accommodations you receive in the United States may not be available at your host program/institution. This information is sought to help you and your host institution explore the availability of appropriate medical and psychological services abroad, including medications. Please feel free to share with us the following information. Please note that based upon the information you provide, you may be asked to provide further documentation from your health care provider before we authorize your participation. Please note that some prescription drugs may not be legally obtainable or readily available in some countries. If you are currently taking a prescription drug on a regular basis, it is YOUR responsibility to take these factors into account as you prepare for studying abroad.

Primary Care Physician (name and phone number). *If you do not do not have a primary care physician, please reply with N/A.*
Mental Healthcare Provider/Counselor (name and phone number) *If you do not do not currently have a mental healthcare provider, please reply with N/A.*
Insurance Company Name and Policy Number:
Are you taking any medications on a regular basis? *Please, identify the medication(s), dosage and frequency and the condition/illness for which the medication is needed:*
Do you anticipate needing any special accommodation(s) on site (including physical or academic)? If so, please describe below.
Do you have any chronic health conditions (i.e., diabetes, asthma, seizure disorders)? *Please, describe:*
If you responded "yes" to the above, does this condition require treatment? *Please, describe the treatment, including any medications:*
Do you have any allergies that require medical treatment? *Please, describe the allergy(ies) and the treatment(s), including medications:*
Do you have any specific dietary restrictions? *Please, describe:*

FINISH THE MEDICAL INFORMATION RELEASE FORM

√	*I CERTIFY THAT ALL OF THE INFORMATION PROVIDED BY ME IN THIS FORM IS TRUE AND COMPLETE.*
FIRST/LAST NAME (student participant)	SIGNATURE
FIRST/LAST NAME (student's parent or legal guardian, if applicable)	SIGNATURE
DATE	