

International Field Studies, Inc.
Medical History Form
****REQUIRED FIELDS****

**LAST NAME	**FULL FIRST NAME	**MID. INITIAL	**GENDER
**BODY WEIGHT	**BIRTHDATE	**COUNTRY OF CITIZENSHIP	
**PASSPORT NUMBER	**EXPIRATION DATE	**VISA NUMBER (IF TRAVELING ON STUDENT VISA)	
ADDRESS			
CITY	STATE	ZIP CODE	
DAY PHONE		EVENING PHONE	
SCHOOL			GRADE JUST COMPLETED
PARENTS NAME			
PARENTS ADDRESS			
CITY	STATE	ZIP CODE	

Medical Information

Indicate if you have had problems with any of the following:

(Elaborate in the space to the left or on a attached sheet of paper if necessary)...

- | | |
|--|---|
| <input type="checkbox"/> ASTHMA
<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> EAR INFECTIONS
<input type="checkbox"/> DIABETES
<input type="checkbox"/> HEARING DIFFICULTIES
<input type="checkbox"/> DIZZINESS
<input type="checkbox"/> CLAUSTROPHOBIA
<input type="checkbox"/> HEART PROBLEMS
<input type="checkbox"/> FREQUENT UPSET STOMACH,
HEARTBURN, INDIGESTION,
ULCERS. | <input type="checkbox"/> FOOT TROUBLE
<input type="checkbox"/> HEADACHES
<input type="checkbox"/> SUN POISONING
<input type="checkbox"/> VOMITING and SEASICKNESS
<input type="checkbox"/> TROUBLE BREATHING THROUGH
YOUR NOSE (except with cold)
<input type="checkbox"/> FEAR OF HEIGHTS.
<input type="checkbox"/> MOOD DISORDER OR
PERIODS OF MARKED DEPRESSION
<input type="checkbox"/> BEE AND/OR WASP STINGS, INSECT BITES.
<input type="checkbox"/> ALLERGIC TO NUTS, PEANUT BUTTER, OR NUT BYPRODUCTS |
|--|---|

List any allergies: _____
List any current medications you are taking: _____ {Please make sure that all medications travel in original containers}

Have you had surgery in the past year? _____ If so, what? _____

Date if last Tetanus shot or booster _____

Are you a vegetarian? _____

Have you had a checkup by a dentist within the last year? _____

Have you had your appendix removed? _____

Do you have any physical impairments that might affect your ability to participate in this program? _____ If yes, please explain: _____

Indicate other special considerations, such as reactions to medications, which we should be aware of:

In the event of either illness or an accident, we will attempt to telephone your guardian and/or your family doctor.

DOCTOR'S NAME _____ PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

Please return this completed form to Carolyn Exner, Room 105 of Achatz

International Field Studies, Inc.
Medical Consent, Release and Assumption of Risk.

Participant's Name _____

As used herein: "FIELD STUDY DIRECTORS" shall include International Field Studies, Inc., its officers, directors, employees, staff, and _____ University of St Francis _____ its teachers, agents, employees, and licensees. "UNDERSIGNED" shall be the father and/or mother, or the guardian of the PARTICIPANT, or the PARTICIPANT if eighteen years of age or older.

The UNDERSIGNED understand that during the field study under the direction of the FIELD STUDY DIRECTORS, certain risks and dangers may occur, including, but not limited to, hazards, accidents or illness of any kind whether foreseeable or unforeseeable, the forces of nature, and travel by airplane, automobile, bus, train, or other conveyance. The UNDERSIGNED understand that many activities associated with the field study and related activities may take place in remote places without medical facilities.

In consideration of the right to participate in this field study and related activities and to utilize the services, including food, as provided, the UNDERSIGNED hereby assume all risks, including those set forth above, and hereby hold the FIELD STUDY DIRECTORS harmless from any and all liability, actions, causes of actions, debts, claims and demands of every kind and nature whatsoever whether foreseeable or unforeseeable, which arise from or in connection with the above described field study and related activities. This release and assumption of the risk shall apply to the negligent acts or omissions of the FIELD STUDY DIRECTORS. The terms hereof shall serve as a release and assumption of the risk for the UNDERSIGNED, his or her heirs, executors, administrators, and members of the UNDERSIGNED's family.

In the event emergency medical treatment is required for the PARTICIPANT while PARTICIPANT is under the control and direction of the FIELD STUDY DIRECTORS, and if consent is a requisite to any such treatment, the UNDERSIGNED hereby grant to the FIELD STUDY DIRECTORS the right to give consent for such treatment for the PARTICIPANT on behalf of the UNDERSIGNED. Said consent may be granted or withheld by the FIELD STUDY DIRECTORS as each of them, in their sole direction, shall determine. The UNDERSIGNED hereby waive any and all claims, which they may have against the FIELD STUDY DIRECTORS arising from the granting or the withholding of the aforesaid consent.

In the event that emergency medical treatment is provided to the PARTICIPANT, the UNDERSIGNED hereby authorize FIELD STUDY DIRECTORS, Broward General Medical Center, and/or any other entity providing medical services or material in conjunction with emergency medical treatment, to seek payment for said services or material and assigns any medical, insurance benefit for same services or material to International Field Studies, Inc. from the following insurers of the PARTICIPANT:

INSURER NAME POLICY NUMBER

The UNDERSIGNED hereby guarantee payment of any medical insurance deductible, any service not covered by PARTICIPANT's insurer, or any other cost incurred in providing emergency medical treatment, to International Field Studies Inc., Broward General Medical Center, and/or any other entity providing or paying for medical services or material in conjunction with emergency medical treatment.

The Undersigned below have read the Medical Consent, Release and Assumption of Risk and hereby voluntarily agree to the same, and have answered all the questions on the Medical History Form (reverse side), to the best of her or his ability:

DATE STUDENT or PARTICIPANT

DATE PARENT(S) or GUARDIAN

Sworn to me and subscribed by _____ in my presence the _____ day of _____, _____.

NOTARY
378006v1

IMPORTANT: EVERYONE MUST HAVE THIS FORM FILLED OUT AND NOTARIZED.