



Medical and Emergency Contact Information

The purpose of this form is to help the MBA & MS Programs Office be of maximum assistance to you should the need arise during your time abroad. Mild physical or psychological disorders can become serious under the stresses of life while studying overseas. It is important that the department is made aware of any medical or emotional problems, past or current, that might affect you in a foreign study context. The information provided will remain confidential and will be shared with the program staff, faculty or appropriate professionals only if pertinent to your own well-being. This information does not affect your admission into the program.

YOUR NAME _____ **DATE** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____

Relationship to You _____

Address _____

Home Phone _____

Work Phone _____

E-Mail Address _____

If there is a physician you feel we might need to contact, please supply their contact information below (optional):

Physician Name _____

Phone _____

I authorize Temple University to release education records and other information relating to me to my parent, legal guardian or emergency contact in any situation that involves health or safety issues.

Signature of Participant _____ **Date** _____

MEDICAL INFORMATION

___Yes___No 1. Do you have any medical conditions, learning disabilities or physical disabilities that would be helpful for the program staff to be aware of? If so, please explain below.

___Yes___No 2. Have you ever been treated or are you currently being treated for physical, psychological or emotional problems that would be helpful for the program staff to be aware of? If so, please explain below.

___Yes___No 3. Do you have any allergies (food, medications, etc.)? If so, please list below.

___Yes___No 4. Are you taking any medications? If so, please list below.

I certify that all responses made on this Medical Information form are true and accurate, and I will notify the MBA & MS Programs Department hereafter of any relevant changes in my health that may occur prior to the start of the program.

Signature of Participant _____ **Date** _____