

MEDICAL STATEMENT

Name of Applicant

Date of Birth

The above applicant is in good state of health and there are no medical objections to his/her participation in the designated academic program.

Does the applicant have any disease or disability which will need continued or periodical treatment?

No Yes (If yes, please specify.)

Does the applicant suffer from allergies?

No Yes (If yes, please specify.)

To your knowledge and based on a recent medical examination, are there any predisposing medical, physical or emotional factors which under academic stress may require treatment while the applicant is enrolled in the program?

No Yes (If yes, please comment.)

Name of Medical Doctor

Address and Phone Number

Signature

Date

MEDICAL HISTORY

Name of Applicant

The information provided will remain confidential and will be shared with administrative staff, faculty or appropriate professionals only if pertinent to your own well-being. This information does not affect your admission to the designated program.

Are you generally in good physical condition?
(If no, please explain.) Yes No

Have you ever been treated or are you currently being treated for any psychological or emotional problems?
(If yes, please explain.) Yes No

Do you have any allergies? (If yes, please explain.) Yes No

Are you taking any medications? (If yes, please explain and print the name of the medication.) Yes No

Have you had any major injuries, diseases, or ailments in the past five years? (If yes, please explain.) Yes No

Are you a vegetarian, or are you on a restricted diet?
(If yes, please explain.) Yes No

Is there any additional information (concerning medical conditions or physical disabilities) that we need to know about?
(If yes, please explain.) Yes No

I, _____, certify that all responses made on this health form are true and accurate, and I will notify Salzburg College of any relevant changes in my health that may occur before departure.

Signature

Date

CONSENT AND RELEASE and MEDICAL COVERAGE

I, the undersigned _____ (print full name)

indicate my desire to enroll in the Program offered through Salzburg College for the _____ (term/year).

I understand that Salzburg College, or any of its officers or employees will not assume any liability for damage or loss of property or for any financial or other obligations incurred by me. I agree to waive any claims which may now or in the future be asserted against Salzburg College for reason of any accidents, injuries or actions by me while in transit to, returning from, or while studying in Salzburg.

I understand that I shall be subject to the supervision and authority of Salzburg College, its officers and employees and acknowledge the fact that they have the right to exclude any student whose conduct or academic standing may warrant such control. I understand that students are expected to attend classes regularly unless otherwise indicated by illness or unavoidable circumstances and are expected to display a sense of maturity and responsibility.

I acknowledge that in the case of withdrawal or dismissal from the designated program, I will not receive any refunds after the program has begun. I also understand that I will no longer have access to any of the facilities arranged for students of Salzburg College.

I understand that by signing this form I am committing to participating in the study abroad program as indicated on the online application form and am also obliged to pay the full tuition due six weeks before the program begins. The starting date is the departure day from the U.S.

I hereby authorize Salzburg College to publish any and all photos and videos taken during my studies in Salzburg and on study trips and field trips for use on the Salzburg College website and all current or future media. I will make no monetary claim.

I further agree that my participation in any publication and website produced by Salzburg College confers upon me no rights of ownership whatsoever. I release Salzburg College and its employees from liability for any claims by me or any third party in connection with my participation.

I hereby authorize Salzburg College to release any information regarding my person to the following: (Please list Names, Email Addresses, Phone Numbers and Addresses of Person(s) you wish Salzburg College to contact in case of an emergency)

I consent to be given medical or surgical treatment as may become necessary for myself and understand that any costs thereof would be borne by me. I also understand that I am responsible to obtain my own medical insurance coverage.

I have the following MEDICAL INSURANCE:

This policy covers doctors and hospital services in Austria, evacuation and repatriation, and any other related emergency treatment.

Signature

Date

Salzburg College • Bergstrasse 12 • 5020 Salzburg • Austria
T: +43 (0)662 842501 • F: +43 (0)662 842501-22 • E: info@salzburgcollege.edu • www.salzburgcollege.edu