



## EMERGENCY INFORMATION

U.S. Passport Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Please attach a copy of your passport. (If currently unavailable, be sure to submit by April 1.)

**In case of an emergency, please contact:**

\_\_\_\_\_

Relationship to me: \_\_\_\_\_

Emergency Contact's Home Phone: \_\_\_\_\_

Emergency Contact's Work Phone: \_\_\_\_\_

Emergency Fax Number (If not known, please locate one with your contact):

\_\_\_\_\_

## Health Insurance

All participants are required to be covered by a medical insurance policy while they are abroad. Please attach proof that your current health insurance will be effective during the dates of travel, and that coverage remains effective when overseas. Such *attached* proof may be:

A photocopy of your insurance card providing the policy number and effective dates, accompanied by an excerpt from your policy clearly stating that coverage extends to your stay abroad.

OR

A letter from your insurance agent specifying the same.

(If your current coverage will not be effective while overseas, we can suggest reputable and inexpensive short-term carriers to you.)

Health Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Health Insurance Carrier's Phone Number: \_\_\_\_\_

## **Medical Information**

The following questions are asked to determine your health history and any special medical needs you may have when you study abroad. Information provided will be treated confidentially. You will not be disqualified from participating based on disclosures below.

Please list any food allergies you have:

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Please list any allergies you have to medications:

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

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Are you currently being treated for any physical conditions?  
(If so, please explain.)

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Do you have any physical limitations that we should be aware of?

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I certify that all responses made on this form are true and accurate, and I will notify the International Engineering Program hereafter of any relevant changes in my health that occur prior to the start of the program. I understand that this form is for information purposes only and in no way implies the University of Rhode Island takes responsibility for my health.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date



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