I hereby grant permission to any licensed physician or dentist to perform emergency treatment on the undersigned student while he or she is participating in the Miami University Travel Program in ___________________________ (Name of Country/ies) from __________________________ through __________________________.

Because of the nature of the program, I further acknowledge and agree that Miami University officials responsible for the program have a need to know and a right to know about medical procedures and the prognosis of any medical condition that may affect my continuing participation in the program. As such, I hereby authorize medical personnel to release medical information relevant to my continuing participation in the ___________________________ (Name of Course or Program) in ___________________________ (Country/ies) to the aforementioned Miami University personnel on a need to know basis.

The following is information concerning medical history, including allergies, medications being taken, and any physical impairments, to which a physician should be alerted:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Date ___________________________ Student’s Signature ___________________________

The original should accompany the director during the study abroad program.

A copy of this form is to be placed on file with the Global Initiatives.