2015 BSOBL European Study Tour Application

Print this application, complete ALL information <u>including the Stevenson University Health Report and Clearance Form,</u> and attach a photocopy of your passport picture page. If you do not have a passport, obtain one and submit a photocopy of passport picture page no later than March 13, 2015. List your name below EXACTLY as is (or will be) on your passport. Full Name *(**EXACTLY** as on passport)*:

First Name *(as you would like to be called)*:

Study Tour Roommate's Name *(if known)*:

Passport #: Date of Birth: Nationality (i.e. USA):

Emergency Contact Name: Emergency Tel #:

SU Email Address: _____@stevenson.edu SU Student ID#:

Major: # SU Credits Completed: [ ] Gender: [ ] Male [ ] Female

Mailing Address:

City/State/Zip: Cellphone #:

Select one: [ ] IS-260 Presentation Theory & App. ($4,299) [ ] IS-475 Special Topics in Info. Systems[1] ($4,299)

[ ] INBUS-415 International Business Mgmt. ($4,299) [ ] BTM-650 Independent Study[1] ($4,299)

[ ] IS-260 and INBUS-415 ($4,999)

[ ] Stevenson alumnus/alumna non-student ($3,899)[2] – Will attend [ ] IS-260 OR [ ] INBUS-415

The first 10 (non-alumni) students to place a $1000 deposit are entitled to a $300 discount off the above prices.

Discount approval signature (Prof. Saulynas):

[1] Must be pre-approved by Prof. Saulynas

[2] Up to 2 alumni may attend. They are not eligible for the student discount. Alumni must choose one course (IS-260 or INBUS-415) and are required to attend all class sessions. They must attend all company visits, events, and excursions.

Submit your initial $1000 deposit payment as follows: [ ] Check - to "Stevenson University"

Credit Card #: [ ] VISA [ ] MasterCard [ ] Discover

Name on Card: Expiration Date:

The full balance is due on March 13, 2015. Cancellations after initial deposit (and by February 13, 2015) will result in forfeiture of $200 of the deposit. Cancellations after February 13, 2015, will result in a forfeiture of the $1000 deposit. There are no refunds after March 13, 2015. **Make additional payments to Student Accounts in Garrison Hall.**

I understand the requirements and payment terms for this program and **agree to make full payment by March 13, 2015**. I understand the cancellation and refund policies stated above. Additionally, I understand that costs for passports, textbooks, food (other than hotel breakfasts), and additional spending money are my responsibility.

Signature: Date:

Return this application, deposit, and passport picture page photocopy to:

Prof. Sy Saulynas, SB 311, Tel: 443-352-4037, eMail: ssaulynas@stevenson.edu

STEVENSON UNIVERSITY STUDY ABROAD PROGRAM
HEALTH REPORT AND CLEARANCE FORM

All students, staff, and guests must have a health clearance in order to participate in the Study Abroad Program at Stevenson University. You must complete Part A of this form accurately and completely and give it to a healthcare provider who has examined you **within the last 365 days**. Your healthcare provider must complete Part B and submit the completed form, parts A+B, to the Stevenson University Study Abroad Office. Failure to provide complete and accurate information or failure to provide this information by the deadline set by the Program may be grounds for denying you participation in the Program. This form will be sent to the Director of Study Abroad and the leader of your program so that he or she may assist you properly in case of an emergency. **Please update Part A and submit it with Part B for each trip you participate in. Part B can be resubmitted within a 365-day period from your last medical exam.**

PART A

(Print) Last Name_____ First _____ Middle _____ Sex __M __F
DOB:_____
SU I.D. #_____ Name/location of Study abroad program_____

Name of the Leader of your Study Abroad Program : _____

Person(s) to notify in case of emergency Phone number(s)

_____ _____

(Name) (Relation) Home Work Cell

Additional emergency contacts:

_____ _____

(Name) (Relation) Home Work Cell

Health professional's name _____ Phone _____
Health Insurance: Policy Number:
Policy Holder:_____ Group Number(if applicable):_____

List all other health professionals (doctor, nurse practitioner, psychologist, counselor, etc.) <u>you have seen in the past year</u> on a separate form, if necessary, and include contact information.

PERSONAL HEALTH HISTORY

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?	CURRENTLY HAVE (Check all that apply.)*	NO LONGER HAVE (Provide date on which you last had condition.)
Asthma/Hay Fever		
Back/joint problems		
Exercise-induced asthma		
Cancer/tumors		
Alcohol/drug dependency		
Chicken pox		
Convulsive Disorders		
Depression/anxiety/bi-polar disorder/panic attacks		
Diabetes		
Eating disorders		
Heart disease		
Hepatitis		
Hypoglycemia		
Kidney Disease		
Migraine headaches		
Mononucleosis		
Other psychiatric disorder		
Stomach/intestinal disorders		
Thyroid disease		
Tuberculosis		

*** Please provide additional information about checked items on an attached sheet.**

1. **Have you had any illnesses, injuries, or medical conditions within the past year for which you have received or are presently receiving professional medical treatment?**

No: _____ Yes:_____

If yes, please describe:

_____

_____

2. **Have you had any mental, emotional or psychological conditions, including eating disorders, within the past year for which you have received or are presently receiving treatment from a mental health professional or substance abuse counselor?**
No: _____ Yes: _____

If yes, please describe:

_____

_____

3. **Do you suffer from any allergies (food, medicine, insects, animals, etc.)? List all or just those that are life-threatening?**
No: _____ Yes: _____

If yes, please describe:

_____

_____

4. **Do you have any dietary restrictions or special dietary needs (including nonmedical restrictions)?**
No: _____ Yes: _____

If yes, please describe:

_____

_____

5. **List any medications you are currently taking and the conditions(s) for which the medication has been prescribed.**

_____

_____

6. **Do you have any physical condition or chronic illness that limits your activities in any way?**
No: _____ Yes: _____

If yes, please describe:

_____

_____

7. Do you maintain any religious or cultural beliefs or practices that would prohibit any medical procedures or treatments in the case of an emergency?
No: _____ Yes: _____

If yes, please describe:

_____

_____

PERMISSION TO SHARE INFORMATION: I hereby give the Director of Study Abroad (and his or her designee) and other representatives of Stevenson University permission to communicate with one another and/or with my parents (in the case of students), immediate family members, emergency contact person(s), doctor(s)

and/or health care professionals regarding my study abroad participation as necessary for university officials to perform their job duties. This may include but is not limited to the release of information from this health care form and my other Stevenson records about my health and safety. In the case of students, this information may include conduct or disciplinary matters, academic issues, account information and/or any other relevant conduct or circumstance before or during the Program experience.

_____ (Traveler's signature)

PERMISSION FOR EMERGENCY TREATMENT AND RELEASE: I grant permission for designated representatives of Stevenson University to consent on my behalf to the provision of emergency medical care, including but not limited to the examination, diagnosis and treatment of any emergency condition or injury I may sustain or experience during the Program. This consent shall include, but not be limited to, emergency blood transfusions, surgical procedures, the administration of anesthesia and other medical tests and procedures recommended by and carried out under the supervision of a qualified medical professional. All such treatment shall be at my expense, and I agree to reimburse Stevenson University and its representatives for any expenses that they or any of them might incur on account of my condition or treatment.

_____ (Traveler's signature)

I HEREBY RELEASE AND AGREE TO DEFEND, INDEMNIFY AND HOLD HARMLESS STEVENSON UNIVERSITY AND ITS EMPLOYEES AND AGENTS FROM ALL CLAIMS, COSTS, FINES, AND/OR LIABILITY FOR ANY BODILY INJURY, PERSONAL INJURY OR OTHER DAMAGE I MAY SUSTAIN (1) AS A RESULT OF ANY MEDICAL TREATMENT DECISION OR RECOMMENDATION MADE BY AN EMPLOYEE OR AGENT OF STEVENSON UNIVERSITY ON MY BEHALF; OR (2) AS A RESULT OF ANY MEDICAL CARE I RECEIVE IN THE HOST COUNTRY, INCLUDING, BUT NOT LIMITED TO, MEDICAL MALPRACTICE OR TREATMENT THAT IS NOT OR MAY NOT BE IN ACCORDANCE WITH U.S. STANDARDS.

_____ (Traveler's Signature)

CERTIFICATION: I certify that:

1. I have personally completed this form. The information contained in this form is complete and I have not withheld any information about my physical or mental health. If any aspect of my health profile changes between submitting this form and my departure for the Program, I will notify the Study Abroad Office of these changes immediately, in writing. I understand that my failure to disclose any medical or mental health information may jeopardize my ability to receive appropriate medical care in the event of an emergency abroad.

2. I am in good physical and mental health and I do not suffer from any mental or physical problem or condition that limits my activities or would prevent me from successfully taking part in the Program in _____, _____.

3. I further understand that, in the event of an emergency abroad, Stevenson University reserves the right to notify my parent(s), guardian, or emergency contact set forth in Part A of this form.

_____ (Traveler's Signature) _____(Date)

PART B

Travel Program Name: _____

TO BE COMPLETED BY A PHYSICIAN OR HEALTH PRACTITIONER WHO HAS SEEN THE TRAVELER WITHIN THE PAST YEAR, AND RETURNED TO STUDY ABROAD OFFICE WITH PART A.

Note to the health professional: *Please attach a blank copy of your office letterhead or a business card and return with Part A via fax or mail, as soon as possible, to Study Abroad Office, Stevenson University, 1525 Greenspring Valley Road, Stevenson, MD 21153.*

Telephone: 443-334-2579 **Fax: 410-486-3552**

The above-named person has been selected to participate in an international study abroad program. Living and studying in a foreign environment often creates unexpected emotional and physical stress which can exacerbate otherwise mild conditions. It is important that all participants be able to adjust to dramatic changes in their living environment, climate, diet, and studying conditions that may disrupt their usual patterns of behavior. Your complete and candid evaluation of the person's physical and mental health is, therefore, extremely important to the Study Abroad Office to appropriately address any problems that might arise during the traveler's international study abroad experience.

HEALTH PROFESSIONAL'S RECOMMENDATION:
Based on the information given by the person on this Health Report, on my personal review of the traveler's health history, on my recent physical examination of the traveler, and on his/her medical records on file in this office, I find:

_____ that this person is fit to study in the foreign country referenced above.

_____that this person is fit to study in the foreign country referenced above, subject to the following conditions: _____
_____
_____

_____ there are medical or psychiatric contraindications to this person's participation and, in my judgment, the person is not cleared to study abroad.

_____ _____
Health Professional's Signature Health Professional's Name (printed)

Date: _____

Study Abroad Office, Stevenson University
1525 Greenspring Valley Road
Stevenson, MD 21153
Phone: 443-334-2579
Fax: 410-486-3552