Acknowledgment of Risks and Release

Hofstra University
Study Abroad Programs

Name: _____

Date of Birth: _____

Student Identification Number: _____

Hofstra University offers its students the opportunity to participate in _____ (program description, location, dates, etc.) ("Program"). Certain potential risks to personal health and safety are associated with travel to and residence in a foreign country. You should not participate in this Program unless you are willing to accept the associated risks. Hofstra University ("University") cannot guarantee the health and safety of participants in this Program or eliminate all risks.

Please read, sign and return this form before participation in the Program. Students who fail to return this form will not be allowed to participate.

- I understand that there are certain risks associated with travel to and residence in a foreign country and that the University, its agents and employees cannot control these risks.
- I understand that these risks may include, but not be limited to, exposure to potentially serious health and safety hazards such as: transportation accidents, storms, floods, earthquakes, and other natural disasters and weather conditions, infectious diseases, inadequate medical care, remote access to medical treatment, political unrest, armed insurrections and terrorist activities.
- I have received and understand the Program itinerary.
- I understand that the University does not represent or act as an agent for, is not responsible for and cannot control the acts or omission of any host institution, host family, transportation carrier, hotel, tour organizer or other provider of goods and services involved in the Program.
- I understand that the University is not in a position to guarantee my personal health or safety during my participation in the Program.
- I understand and hereby acknowledge that I assume all risks incurred by my participation in the Program.
- I understand that I am responsible for my medical or medication needs and further agree that if I become incapacitated, the University, through its agents and employees, may take whatever action is deemed necessary with respect to my health and safety. I authorize the University, its agents and employees, to place me, at their discretion and without my further consent, in a hospital or in the care

of a medical professional for medical services and treatment. I understand that I am required to have an insurance policy that covers risks associated with travel abroad, such as medical evacuation and repatriation, during the period of the Program and I take full responsibility for knowledge of limitations of my insurance coverage pertaining to travel abroad. I agree that I will be fully responsible for any and all expenses associated with or in any way related to my health and safety.

- I agree that the University is not responsible for my welfare during periods of independent travel or absence or separation from the Program.
- I understand that each foreign country has its own laws and standards of acceptable conduct including dress, manners, morals, politics and behavior. I will become informed of and will abide by all such laws and standards of behavior.
- I understand and agree to comply with the University's rules, standards and instructions for behavior. I understand that the University and its agents and employees have the right to enforce standards of conduct and may at any time terminate my participation in the Program for failure to maintain these standards or for any conduct which the University or its agents consider to be incompatible with the interest and welfare of the other students or host institution. If I am expelled from the Program, I agree that I will return home at my own expense and acknowledge that I will not receive any refund of Program fees and expenses.
- I understand that should I encounter any personal legal problems, the University is not responsible for providing any assistance in such circumstances.
- In consideration of being allowed to participate in the Program, I hereby release the University, its trustees, officers, agents and employees from any and all losses to person or property, claims, damages, demands, and actions arising out of or in any way connected with the Program and my participation therein, including, but not limited to, the risks as outlined above.

I have read the foregoing before affixing my signature below, and warrant that I fully understand the contents thereof.

_____ _____

Signature of Student Date

If student is under the age of 18, parental consent is required.

The undersigned parent or legal guardian of the above named student, hereby consents to the participation of the student in the Program and acknowledges understanding and agreement with the foregoing statements.

_____ _____

Signature of Parent/Legal Guardian Date

Hofstra University
Study Abroad Programs
Medical Information Form

This form is to be completed by the participant. The purpose of this form is to enable Hofstra University to provide appropriate assistance to you should the need arise during your study abroad experience. It is important that we be aware of any medical or emotional problems, past or current, which might affect your ability to participate in the study abroad program. Please be honest and comprehensive. The information provided will remain confidential as allowed by law and will not be used to disqualify you from the program. Relevant information will be shared with program staff, faculty, or appropriate professionals as it relates to your health and safety.
Hofstra University shall not be responsible for participant's failure to provide complete and accurate information.

Student's Name:_____ Hofstra ID#:_____

Sex: □ F □ M Date of Birth:_____ Citizenship:_____

Current Address:_____

Phone:_____

Name of Study Abroad Program:_____

Country/Countries of Program:_____ Dates of Program:_____

This information is required to coordinate treatment in the event of a medical emergency. If you answer YES to any of the following questions, please provide details of the condition and the treatment you received or are continuing to receive. Please contact us if any conditions or treatments change before the start of your program.

Are you currently under medical treatment? If yes, explain.

_____
_____
_____
_____

Are there any medical conditions that we should be made aware of? If yes, explain.

_____
_____
_____
_____

Do you suffer from any allergies? If yes, explain.

_____
_____

Are you currently taking any medications? If so, specify.

Do you have a disability that will require accommodations while abroad? If so, explain.

Are you allergic to any medication? If yes, explain.

Do you suffer from any food allergies or have any dietary restrictions? If so, explain.

Additional Health Conditions

Do you have any additional health conditions other than those previously listed (such as surgeries, hospitalizations, injuries, chronic conditions, physical illness, psychological illness, emotional illness, mental illness, etc.) that may need special consideration before or during your experience or may affect your ability to participate in this program?

□ yes □ no

If yes, you are advised to consult with your health care provider. Please provide an explanation below:

Physician Information

Physician's Name:_____
Physician's Address:_____

_____
Physician's Phone:_____

Authorization Statement

I hereby authorize the release of information from my medical history upon the request of Hofstra University's Study Abroad Programs. I further authorize the release of information by the Study Abroad Program to its affiliated institutions. I certify that the information on this Medical Information Form is true an correct, and I will notify Hofstra University's Study Abroad Program hereafter of any relevant changes in my health that occur prior to the start of the program. I understand that this information will be used only for the purposes for which it was prepared.

Student Name:_____

Signature:_____
(or if under 21 Parent/Guardian Signature)

Date:_____

Hofstra University
Study Abroad Programs
Emergency Medical Care Authorization

Emergency Medical Care Authorization

On occasion a student participating in an overseas study program may face a health emergency requiring local hospitalization and emergency treatment. For such an emergency Hofstra University requires that the student and his/her parent or guardian sign the following statement and that ***the student carry it on his/her person at all times while he/she is abroad.***

Name:_____ Hofstra ID #:_____
Sex: □ F □ M Date of Birth:_____

Current Address:_____
_____

Telephone Number:_____
Student's Blood Type:_____
Known Allergies to Medication:_____

Emergency Contact Information

In the event of an emergency abroad, Hofstra University may notify the following emergency contacts:

Emergency Contact 1

Name: _____
Relationship: _____
Address: _____
Phone: _____

Emergency Contact 2

Name: _____
Relationship: _____
Address: _____
Phone: _____

To prevent delay in the event of an emergency requiring hospitalization and/or surgery, I hereby authorize the appropriate authority of the Hofstra University program to secure whatever treatment is deemed necessary for me/my child including the administration of an anesthetic and/or surgery.

_____
Student's Signature (or if under 21 Parent/Guardian Signature)

_____
Date

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Make a copy of this form and keep it on your person at all times while abroad.

Hofstra University
Study Abroad Programs
Publicity Release

I hereby agree, beginning as of the date of execution of this Release, that photographs, whether still or action, videos, film and/or motion pictures (hereinafter "Pictures"), and/or audio recordings ("Recordings"), may be taken of me, individually or with others, by or on behalf of the University in connection with the Program and agree that all rights therein shall irrevocably, exclusively, unconditionally and perpetually belong to the University and that such rights are freely assignable by the University.

I further agree that, without any compensation or notification to or approval by me, the Pictures or Recordings may be used, reproduced or otherwise disseminated or published by or on behalf of the University directly or indirectly for any purpose, including but not limited to advertising and/or promotional purposes, in any manner, and at any time that the University desires.

For good and valuable consideration, receipt of which is hereby acknowledged, I hereby agree on behalf of myself, to release and discharge the University, its officers, representatives, employees, agents, licensees, successors and assigns from any and all claims, demands or causes of action that I may now have or may hereafter have for libel, defamation, invasion of privacy or right of publicity, infringement of copyright or violation of any other right arising out of or relating to any utilization of the Pictures or Recordings.

I have read the foregoing before affixing my signature below, and warrant that I fully understand the contents thereof.

_____ _____

Signature of Student Date

If student is under the age of 18, parental consent is required.

The undersigned parent or legal guardian of the above named student, hereby consents to the participation of the student in the Program and acknowledges understanding and agreement with the foregoing statements.

_____ _____

Signature of Parent/Legal Guardian Date

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10/7/04