Liberty University Study Abroad
Student Information & Health Report

PERSONAL INFORMATION (please print clearly)

Name: _____ Student ID: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Will you be taking this cell phone with you while out of the country? (Check with carrier) YES NO

LU Email: _____ Box #: _____
IMPORTANT: LU will use this email address to stay in contact with you while you are abroad.

Date of Birth: _____ Social Security #: _____
(Optional — medical insurance purposes only)

Gender: ☐ Male ☐ Female

MEDICAL INSURANCE INFORMATION

Medical Insurance Name: _____ Medical Insurance Policy #: _____

I have checked with my medical insurance company and it:

☐ does cover me while I am out of the country

☐ does not cover me while I am out of the country. My out of country medical insurance coverage plans are:

Name of alternative medical insurance: _____ Policy #: _____

STUDY ABROAD INFORMATION

Study Abroad Program: _____ Country/Countries: _____

Dates of Program: _____ Exact Dates of Travel: _____
(incl. additional travel dates) to purchase International Insurance

Passport #: _____ Passport Expiration Date: _____
(Please provide the Office of Study Abroad a copy of your passport)

I give permission to the Study Abroad Office to share my email address with other prospective study abroad students YES NO

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: _____ Cell: _____

HEALTH INFORMATION

Primary/Family Doctor: _____ Phone Number: _____

- ☐ I have reviewed the participant's medical information and history
- ☐ I have performed a physical exam
- ☐ I have explained recommended immunizations, preventive treatments, and travel instructions to the participant

Please choose one

- ☐ I find the participant to be in adequate health for participation in the above-named program with no restrictions
- ☐ I find the participant to be in adequate health for participation in the above-named program with the following restrictions:

_____

- ☐ I do not recommend the participant for the above-named program at this time

Healthcare provider signature: _____ Date: _____

LIBERTY UNIVERSITY™

Study Abroad