

**Part I.**  
**Confidential Health Record**

After acceptance to program, please provide the information below that will help our staff obtain medical assistance for you in the case of accident or illness; incomplete medical records can delay treatment. It is therefore important that you provide any information that might be relevant in a medical emergency. Also, it is important that while you are traveling you continue any medical treatment or medication that you are currently receiving. We recommend that you keep a copy of this form on your person at all times while traveling.

Student Information

1. Student Name \_\_\_\_\_
2. SSN (for Bursars Office) \_\_\_\_\_
3. Student UGA ID # \_\_\_\_\_
4. Student Birth Date \_\_\_\_\_
5. E-mail Address \_\_\_\_\_
6. Summer telephone # \_\_\_\_\_
7. Course selection (circle one)      ANTH4270      FORS4270  
    ANTH6270      FORS6270

Person to Notify in Case of an Emergency

1. Name \_\_\_\_\_
2. Relationship \_\_\_\_\_
3. Phone (cell or home) \_\_\_\_\_
4. Address \_\_\_\_\_
5. E-mail \_\_\_\_\_

Food Preference

Are you (circle one)                      Vegetarian                      Non-vegetation

Orientation

I have reviewed and understood the on-line Mandatory Pre-departure Program Orientation available at <http://discoverabroad.uga.edu/programs/summer/united-states/> (circle one)      YES              NO

(If no, you must email [DiscoverAbroad@uga.edu](mailto:DiscoverAbroad@uga.edu) immediately with questions that you have)

Medical Conditions

1. Are you currently receiving, or have you recently received any medical or psychological care of which you want us to be aware in case of an emergency? If so, describe fully.

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2. List any other on-going physical or emotional conditions which might require treatment abroad, or that might be exacerbated by changes in the environment, diet and exercise. What treatment is recommended?

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3. What medications are you taking on an ongoing basis? \_\_\_\_\_

*Reminder:* Bring enough medication to cover you for your time traveling plus one extra week.

4. What medications or other substances are you allergic to? \_\_\_\_\_

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5. Are you on a medically restricted diet? If so, give details. \_\_\_\_\_

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6. Do you have a physician who should be consulted in case of an emergency? If so, list name and phone number.

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Other

Please note: You are fully responsible for any medical treatment while participating in the program, as medical insurance coverage is not provided by the program.

Photo release: I grant permission for photos of myself to be used in publications by the Great Smoky Mountains Institute (GSMIT). (Circle one)                      YES                      NO

Are you currently on the GSMIT mailing list? (Circle one)                      YES                      NO

It is expressly understood and agreed that GSMIT shall not be responsible or legally liable for any losses of personal property or for any bodily injuries, or the results thereof, incurred and suffered by the applicant or in connection with any activities or programs, unless such loss or injury results directly from the negligent or willful act of an employee of GSMIT acting within the scope of his/her employment.

I certify that I am over 18 years of age.

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Signature

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Date

**Part II.**

**Release, Waiver of Liability and Covenant Not to Sue to Be Signed by Participant**

I hereby acknowledge my awareness that my participation in the **University of Georgia (UGA) Great Smoky Mountains (GSM) Field Program** may expose me to risk of property damage and bodily or personal injury, including death. I understand that the risks that I may encounter include but are not limited to transportation accidents, terrorist incidents, drowning, criminal acts, and sickness including Hepatitis B, Rabies, and cryptosporidium diarrhea, tetanus, poisonous plants, as well as other risks that may not be foreseeable. I have been informed and understand that there are inherent risks and dangers involved in the **UGA GSM Field Program** activity. I knowingly and freely assume any and all such risks and voluntarily participate in the **UGA GSM Program** activity.

In exchange for the use of equipment, materials, supplies and for being allowed to participate in this event, I hereby release and forever discharge the University of Georgia, the Board of Regents of the University System of Georgia, their members individually and their officers, agents and employees from any and all claims, demands, rights, expenses, actions, and causes of action, of whatever kind, arising from or by reason of any personal injury, bodily injury, property damage, or the consequences thereof, whether foreseeable or not, resulting from or in any way connected with my participation in this activity.

I further covenant and agree that for the consideration stated above, I will hold forever harmless and will not take legal action against the University of Georgia, the Board of Regents of the University System of Georgia, its members individually, and their officers, agents, and employees for any claim for damages arising or growing out of my participation whether their actions were negligent, willful, or intentional.

I certify that I am at least 18 years of age, or, if not, that I have secured below the signature of my parent or legal guardian as well as my own. This consent is given freely and voluntarily by me without coercion, duress, threat or promise of any kind. I certify that I understand and have read the above carefully before signing. I understand that I am not subject to any adverse action if I do not sign.

\_\_\_\_\_  
**Signature of Student**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Student**

**Part III.  
Special Accommodations**

UGA field programs endeavor to provide reasonable accommodations for students with *documented* disability conditions (e.g., physical, learning, psychological, etc.). If you are receiving disability-related accommodations at UGA or your home university or anticipate needing them while traveling, attach documentation confirming the disability and information about accommodations currently provided to you (e.g., a letter from Disability Services in Clark Howell Hall - 542-8719 or the Learning Disabilities Center in Milledge Hall - 542-4589). If you do not disclose disability-related needs prior to the program, it will cause a delay in arranging special accommodations. Please provide this information at least 6 weeks before the start of the program to allow time to arrange for accommodations.

Please provide details relevant to your request for accommodation(s) below (indicate "None" if not applicable).

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Decline to Complete Form**

I decline to complete this form and do not wish to share any medical information with the program.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date