

WESTCHESTER COMMUNITY COLLEGE  
CAMBRIDGE STUDY ABROAD PROGRAMME

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MEDICAL INFORMATION FORM

STUDENT'S NAME: \_\_\_\_\_

In the event of sudden illness or injury, you may require immediate medical attention while you are abroad. Please list all health conditions or allergies that medical personnel should be aware of before administering treatment in your case:

Emergency Contact Information:

Full name \_\_\_\_\_

Current Address \_\_\_\_\_

Tel. \_\_\_\_\_ E-mail \_\_\_\_\_

I hereby confirm that the information listed above is complete and accurate.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

If the student signing above is not yet 18 years of age, the parent or legal guardian of the student must also sign and date this form.

\_\_\_\_\_  
Signature of above-named student's parent/guardian

\_\_\_\_\_  
Date