MEDICAL RELEASE RECORD

I, (student), hereby authorize Fairfield University to release to the
emergency medical personnel and Assist America, its officer, employees and/or affiliates, my individually
identifiable health information contained herein in the event of an emergency during my participation in the
{Name of Program} in (location/term). This
information is strictly for use in the event of an emergency and will not be released to any parties for any reasons
other than treatment of the student in an emergency situation. I further understand that upon completion of the
program, if no emergency occurred requiring the use of this information, this information will be returned to me in
the original sealed envelope.
the original scaled envelope.
Name of Student
Signature of student
Date (month/day/year)
Diagramina as much detail as possible in answering the following questions and do not leave any questions blank
Please give as much detail as possible in answering the following questions, and do not leave any questions blank.
Please provide any additional information or records that could be useful in the event that treatment is required
by a doctor or other medical facility abroad. You may add additional pages as appropriate.
Health Conditions:
Describe in detail any physical or mental health conditions, disabilities, or impairments.
Allergies:
Please indicate all known allergies, how you react to it, and any medications that should or should not be used by
you as a consequence of your allergies.

How was the cor	ndition/allergy treate	ed and for how long? (G	Give specific dates, medicatio	ns, etc.)
What is the pres	cribed plan in the evo	ent that a condition/al	lergy becomes an acute or er	mergency situation?
Please list any su	rgeries, describe the	condition requiring th	ne surgery and the date of the	e operation:
Current Medicat	ion Information:			
of Medication	Recommended dosage	Medical reason for medication	List any Contraindications	Acceptable alternate medi if not available abroad
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