PARTICIPATION APPROVALS

Name: ____________________________  Student ID#: ____________________________

Program: _________________________  Major: ____________________________

Semester of Study Abroad: Spring 20 __ Summer 20 __ Fall 20 __ Winter 20 __

By signing this form I certify that I understand and accept that I am responsible for the duties related to my participation in a study abroad program and authorize the release and sharing of my confidential records among university offices. If there is the possibility of a change in my current status, I must discuss my case with my academic advisor and program director, otherwise, I may no longer qualify for enrollment, and I may not be eligible for a refund.

A. 
___I hereby certify that the student listed above does not have any disciplinary reports.
___I hereby certify that the student listed above has had the following disciplinary reports:

B. 
___I recommend that this student participate in this study abroad program.
___I DO NOT recommend that this student participate in this study abroad program.

Certified by: _____________________________________Signature:____________________Date:_____/_____/_____

To be completed by the Dean of Students Office (LBJ 5-9.1)

To be completed by the Academic Advisor (Advising Center in College)

I hereby certify that the student listed above meets all the academic requirements to participate in this study abroad program and is approved to take any of the following courses:

Course 1: Number ___________________________ Title: _________________________________________________
Course 2: Number ___________________________ Title: _________________________________________________
Course 3: Number ___________________________ Title: _________________________________________________
Course 4: Number ___________________________ Title: _________________________________________________
Course 5: Number ___________________________ Title: _________________________________________________

Comments: _____________________________________________________________________________________
______________________________________________________________________________

Advisor's Name: ____________________________Signature: ______________________Date: _____/_____/_____

To be completed by the Academic Program Director (APD)

I have completed the interview, reviewed application and recommendations and hereby certify that I have accepted the student listed above to participate in the study abroad program that I am directing.

APD's Name: ____________________________Signature: ______________________Date: _____/_____/_____
HEALTH INFORMATION

Student's Name:_____________________________________Student ID#:________________________________
DOB:_____/_____/______	 	 	 Gender:  F	  M
Program:__________________________________________________ Country: ______________________________
City:______________________________________________________ Semester: ____________________________
The purpose of this form is to help Texas State to be of maximum assistance during your study abroad experience. Mild
physical or psychological disorders can become exacerbated with the stresses of life while studying abroad. It is important
that the program be made aware of many medical or emotional problems you have experienced. The information provided
will remain confidential and will be shared with program staff, faculty, or appropriate professionals only if necessary to your
wellbeing. Texas State may not be able to accommodate all individual needs or circumstances. This information does not
affect your admission into the program.

Yes___ No___  1. Are you generally in good physical condition? (If no, please explain)
Yes___ No___  2. Have you ever been treated or are you currently being treated for any psychological or
emotional problems? (If yes, please attach explanation.)
Yes___ No___  3. Do you have any allergies? (If yes, please attach explanation.)
Yes___ No___  4. Are you taking any medications? (If yes, please attach explanation.)
Yes___ No___  5. Have you had major injuries, diseases, or ailments in the past fives years? (If yes,
please attach explanation.)
Yes___ No___  6. Are you a vegetarian or are you on a restricted diet? (If yes, please attach
explanation.)
Yes___ No___  7. Is there any additional information (concerning medical conditions or physical
disabilities) that would be helpful for the program to be aware of during your study abroad experience? (If yes, please attach explanation.)

Name and telephone number of physician: ______________________________________________________________ Telephone: __________________________

I certify that all responses made on this Health Information form are true and accurate, and I will notify
the Texas State Study Abroad Office hereafter of any relevant changes in my health that occur prior to
the start of the program.

Signature of participant:_________________________________________________Date:_____/_____/______
Parent/Guardian’s signature (if student is under 18): ________________________Date:_____/_____/______

In the event of an emergency, illness or injury affecting (my son, my daughter, my ward, or myself),
______________________________________________ (student’s name), born_____/_____/______ (date), the
undersigned hereby authorizes immediate hospitalization and treatment recommended by and carried
out under the supervision of a qualified physician, including administering anesthetic and performing
necessary surgery.

Known allergies to medication:____________________________________________________________________

Student’s blood type, if known:____________________________________________________________________

Signature of participant:____________________________________________________Date:_____/_____/______
Parent/Guardian signature (if student is under 18): ____________________________ Date_____/_____/______