HEALTH DISCLOSURE

In the event of any medical emergency (physical or mental), the student hereby grants to JCC or any of its representatives on the Program the full authority to take any action deemed necessary to protect the student's mental or physical health and safety at the student's own expense, including, but not limited to, placing him/her under the care of a doctor or hospital or any place for medical examination and/or treatment or returning the Student to the United States, if such return is deemed necessary after consultation with medical authorities (this could result in some expense to the student). In the event the Student is returned to the United States, the student shall not recover any money paid to JCC in connection with the Program. The student agrees JCC is not required to take any such actions if it is not aware of the emergency or in its discretion determines no emergency exists. Should the need arise; JCC is authorized to provide any personal information of Student to any healthcare provider.

Please read these forms and follow all instructions for completion. **FULL DISCLOSURE IS REQUIRED. The information on these forms will assist healthcare providers in the event of a medical emergency. It is very important that all sections are fully and accurately completed. If a question is not applicable, enter N/A**.

STUDENT NAME: ____

HOME ADDRESS: ____

CITY: _______________________ STATE: _________________ ZIP CODE: ___________

MAILING ADDRESS: ____

CITY: _______________________ STATE: _________________ ZIP CODE: ___________

HOME PHONE: ________________________________ ALTERNATE PHONE: __________________

- -

First Emergency Contact:

Name: _______________________________________ Relationship: ________________________

Address: _____________________________________ City: ___________ State: _________ Zip: _____

Home Phone: _________________________________ Cell/Secondary Phone: ____________________

Second Emergency Contact:

Name: _______________________________________ Relationship: ________________________

Address: _____________________________________ City: ___________ State: _________ Zip: _____

Home Phone: _________________________________ Cell/Secondary Phone: ____________________

Primary Care Physician:

Name: ___________________________________ Office Phone: ___________________________

Insurance Carrier: __________________________ Policy Number: __________________________

*Medical insurance is required for course participation. Healthcare providers may require proof of ability to pay for services before services are rendered. You __**must**__ provide the name of the carrier and the policy number in the blanks above.*

Certification of Immunization

Name	Date of Birth
Street Address	City, State, Zip Code
Phone #	Mobile Phone

Vaccine	Date Given	Vaccine	Date Given
DTP/DTap/Tdap (Diphtheria-Tetanus-Pertussis)		Varicella (Chickenpox)	
Td (Tetanus-Diphtheria)		MMR #1	
OPV/IPV (Polio)		MMR #2	
Hep B (Hepatitis B)		Other:	
Hep A (Hepatitis A)		Other:	
HPV (Human Papillomavirus)		Other:	

The student named above is traveling to Brazil for a 30 day period and we have discussed immunization recommendations.

Signed ________________________________ Title _____________________________ Date ___________
(Physician, Nurse or Health Professional)