

# Student Medical Form <sup>1/2</sup>

Acceptance Packet Form 1 of 5 (Please print legibly or type)

*PASCA maintains and adheres to FERPA guidelines for student records as well as the pre-existing Student Affairs policies of their home institutions. The information provided on this form will be shared with the on-site director at Pont-Aven. Information will be kept strictly confidential unless it becomes necessary in an emergency on a need to know basis. Disclosure is voluntary.*

All students traveling abroad are required by law to have health insurance. If you are not currently covered you must seek temporary health insurance to cover you while you are part of the PASCA program. PASCA requires that you see your physician if it has been over a year since your last physical examination. Students are urged to bring sufficient medication to cover the duration of their stay abroad.

## Personal Information

Name	Date of Birth (MM/DD/YYYY)	Passport #
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## Emergency Contacts

### Emergency contact 1

Name	Relation to you	Place of Employment
Address	Daytime Phone	Evening Phone

### Emergency contact 2

Name	Relation to you	Place of Employment
Address	Daytime Phone	Evening Phone

## Health Insurance

Type of Coverage	Subscriber Name	Subscriber Phone #
Policy Number	Group Number (if applicable)	Company (if applicable)

## Medical History

Please list any allergies:

Do you have any medical conditions?

Please list any medications you are currently taking (including dose and chemical name). Please state for what condition you are taking that medication:

I hereby certify that this information provided here within is accurate, and I will maintain health insurance coverage while studying at the Pont-Aven School of Contemporary Art

Name	Date	Signature
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Please return this form within two weeks of your receipt to:

**Pont-Aven School of Contemporary Art**  
**Acceptance Processing**  
**928 Smith Street**  
**Providence, RI 02908 USA**

Fax: 401 272 5448  
 Tel: 401 272 5445

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**This portion of the form must be completed by a licensed physician.**

<b>Medical Certification of Health</b>	
Patient Name	Date of Birth (MM/DD/YYYY)
Does the individual listed above have any physical or psychological conditions that would hinder their ability to be successful for a one to three month international study program? (please list if applicable)	
Date of patient's most recent physical examination?	
Date of patient's last tetanus booster?	

<b>Physician Statement</b>		
I, _____ (please print name) verify that the individual named above is in good physical health for international travel and study.		
Physician Signature	Printed Name	Date
Business Address	City / State	Zip Code
Office Phone #	Office Fax #	Email Address

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