WOFFORD

# Medical Service Authorization
# Travel / Study Projects

Medical service to provide appropriate treatment for any illness or injury befalling the student named below during the travel/study project in which he or she is to be a participant is hereby authorized, with the understanding, nevertheless, that every reasonable effort, time permitting, will be made to contact the undersigned parent or guardian before any such medical treatment of a major nature is undertaken.

**Name of Student:** _____

*Last, First Middle*

**Number and Title of Interim Project and name of sponsoring faculty member(s):**

_____

Student's permanent address:

_____

*Street/Route/Box No.* *City* *State* *Zip*

Wofford ID: _____ Date of Birth:_____ Age _____

Passport Number:_____ Date of Expiration: _____

Parent or Guardian's Name(s)_____

Tel: Home (_____)_____-_____Business (_____)_____-_____ Cell (_____)_____-_____

Student's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

*Please sign and return promptly to the project faculty sponsor.*

**Students traveling overseas have purchased Wofford's mandatory international insurance for medical coverage**:
Provider: Cultural Insurance Services International
Address of Provider: River Plaza, 9 West Broad Street, Stamford, CT 06902-3788
Telephone 1-800 303-8120