Suffolk
COUNTY COMMUNITY COLLEGE

STUDY ABROAD PROGRAM

STUDENT PACKET

Suffolk
COUNTY COMMUNITY COLLEGE

March, 9 2015

Dear Student,

Congratulations on your decision to join Suffolk County Community College Study Abroad program this summer!

By deciding to study abroad you have made a commitment that will not only contribute to your academic success but also will help you in the future to better market your skills in the workforce or enhance your application when applying to a 4 year academic institution. You are curious, motivated, willing to take a ris explore new horizons and challenge yourself – that is pretty awesome!

Please, find attached a number of documents we need you to fill out to help us make your trip safe and enjoyable. Please, note – you need to visit your physician. **Please, make sure you get your doctor's office stamp on the appropriate form, along with the doctor's signature.** OCA Form No.: 960 must be submitted us as well.

IN ADDITION to the attached documents, please, send to us a READABLE copy of the front page of your passport as well as your airline ticket reservation with all connections' details. All documents will be stor securely.

We MUST have all forms and requested documents on file at Study Abroad Office **2 weeks prior to your departure.** Please, mail them or drop them off to:

Study Abroad Office 533 College Road, Riverhead Building, Room 319 Selden, New York 11784

You will not be allowed to remain on location without your file being complete.

If you have any questions or concerns, please, email tripole@sunysuffolk.edu or studyabroad@sunysuffolk.edu. You can call us at 631 451 4430.

With best regards,

Study Abroad Team

Suffolk
COUNTY COMMUNITY COLLEGE

PARTICIPANT VITAL DATA FORM

PARTICPANT VITAL DATA FORM TO RETAIN ON-SITE BY PROGRAM DIRECTOR

NAME: _____
First Middle Initial Last

HOME ADDRESS: _____

CONTACT PHONE: _____

PASSPORT NUMBER: _____

PROGRAM: _____

AIRLINE & FLIGHT NUMBER: _____

LEAVING DEPARTURE TIME: _____
ARRIVAL TIME: _____

RETURNING DEPARTURE TIME: _____
ARRIVAL TIME: _____

EMERGENCY CONTACT:

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

MOBILE PHONE: _____

EMAIL ADDRESS: _____

Suffolk
COUNTY COMMUNITY COLLEGE

STANDARDS OF CONDUCT

Participant Name: _____ **Phone Number:** _____

Emergency Contact: _____ **Phone Number:** _____

Parent/Guardian Name: _____ **Date of Birth:** _____
(If Participant is under 18 years old at time of application) *(If Participant is under 18 years old at time of application)*

If Participant is under 18 years of age at time of application, a parent or legal guardian must also read and sign this form

Programme: _____ **Travel Dates:** _____

By signing below, I hereby agree as follows:

1. I understand that as a Participant in the indicated Study Abroad Program (the "Program"), I represent Suffolk County Community College (the "College") and the United States of America. Therefore, I will ensure that my deportment reflects positively upon both.

2. I understand that each country has its own laws and standards of acceptable conduct, including culture, dress, manners, morals, and politics. I recognize that any behavior that violates those laws or standards could harm the College's relations with those countries and the institutions therein, as well as my own health and safety. Therefore, I will become and keep informed of, and will at all times abide by, all laws and standards for each country to, or through, which I will travel during the Program.

3. I will at all times comply with all rules, standards and instructions for student behavior, including, but not limited to, all those set out in the *Student Code of Conduct*. I have previously received a copy of the *Student Code of Conduct* and hereby agree to comport myself in compliance with the contents therein, which include, but are not limited to:

    a. **A PROHIBITION AGAINST PUBLIC INTOXICATION, FOR WHICH THERE IS A ZERO TOLERANCE.**

    b. **A PROHIBITION AGAINST ILLEGAL DRUG USE, FOR WHICH THERE IS A ZERO TOLERANCE.**

    c. **A PROHIBITION AGAINST ANY DISRUPTIVE BEHAVIOR, FOR WHICH THERE IS A ZERO TOLERANCE.**

    d. **A PROHIBITION AGAINST OVERNIGHT STAYS BY FAMILY MEMBERS OR FRIENDS FOR ANY REASON.**

    e. **A PROHIBITION AGAINST ENTERTAINING ANY UNAUTHORIZED VISITORS IN APARTMENTS OR ROOMS.**

4. I agree that the College has the right to enforce the standards described above and in the Student *Code of Conduct,* in its sole judgment, and that it will impose sanctions, up to and including **expulsion from the Program**, for **violating** these standards or for any behavior detrimental to or incompatible with the interest, harmony, and welfare of the College, the Program or other participants. **If I am expelled, I consent to being sent home at my own expense with no refunds.**

5. I will attend to any legal problems that I may encounter with any foreign nationals and/or with the government and authorities of the host country. The College is not responsible for providing any assistance under such circumstances.

6. I understand that participation in the Program requires a financial commitment. I therefore agree to make all payments required to secure my travel, transportation, lodging, subsistence, access to local sites and other facets related to the Programme **prior to the deadline of** _____. I hereby accept that failure to tender the requisite payments prior to the indicated deadline may preclude and prohibit my participation in the Program.

7. I understand that if I elect to withdraw from the Program for any reason, my withdrawal request must be submitted in writing to the Program **prior to the deadline of** _____. I hereby accept that failure to meet the withdrawal deadline will preclude and prevent the refund of any monies that I have previously tendered in fulfillment of Program obligations.

X _____ _____
Signature of Student (Parent / Legal Guardian – check below) *Date*

□ I (A) am the parent/legal guardian of the above Participant, (B) have read the foregoing Standards of Conduct, (C) am and will be legally responsible to the obligations and acts of the Student as described in this form, and (D) agree, for myself and for the Participant, to be bound by all of its terms.

Suffolk
COUNTY COMMUNITY COLLEGE

ASSUMPTION OF RISK & RELEASE FORM

THIS IS A RELEASE OF LEGAL RIGHTS - READ AND UNDERSTAND BEFORE SIGNING

Participant Name: _____ **Phone Number:** _____

Emergency Contact: _____ **Phone Number:** _____

Parent/Guardian Name: _____ **Date of Birth:** _____
(If Participant is under 18 years old at time of application) *(If Participant is under 18 years old at time of application)*

Programme: _____ **Travel Dates:** _____

I hereby agree as follows:

1. **Risks of Study Abroad.** I understand that participation in the Program (the "Program") provided by Suffolk County Community College (the "College") and/or the Suffolk Community College Association, Inc, (the "Association") involves inherent risks. These risks include, but are not limited to, travel to, from, and within, one or more foreign countries; local cultural, political, social, legal and economic conditions; different standards of design, safety, and maintenance of buildings, public spaces, conveyances; weather and the environment; the availability and quality of medical care; and other matters that may not be anticipated. I acknowledge that all risks cannot be prevented. I have made my own investigation into and am willing to accept, these risks.
2. **Institutional Arrangements.** I understand that the College/Association does not represent, act as an agent for, and cannot control the acts or omissions of any sponsor, institution, host organisation, host family, transportation carrier or company, hotel, lodging, tour organizer or operator, and/or other goods or service provider. I understand that the College is not responsible for matters that are beyond its control and I assume those risks. I hereby release the College/Association from any injury, loss, damage, accident, delay, fee or expense arising out, or in relation to, any such matters.
3. **Independent Activity.** I understand that the College/Association is not responsible for activities or actions that I undertake, and/or any injury or loss, including death, that I may suffer, whilst traveling or engaging any activity independent of, or otherwise separated or absent from, College supervision. I hereby release the College/Association from any injury, loss, damage, accident, delay, fee, or expense arising out, or in relation to, any such matters.
4. **Program Changes.** The College has the right to make cancellations, substitutions or changes due to, or related to, emergencies, changed conditions, or in the interest of the Program. I understand that the College's fees and program charges are based on current airfares, lodging rates and travel costs, which are subject to change. *If I leave or am expelled from the Program for any reason, I understand and hereby accept that there will be no refund of fees paid.*
5. **Payment of Fees.** I agree to abide by all deadlines for Program fee payments. I further acknowledge and accept the schedule for refunds should I withdraw from the Program. I hereby accept any/all penalties associated with late withdrawal.
6. **Health and Safety.** There are no health-related reasons or problems that preclude or restrict my participation in this Program. I have consulted with a medical doctor with regard to my personal health and medical needs, and I have, in good faith, signed and submitted Medical History/Health Clearance form. I understand that the College is not obligated to provide for any health and medical needs, and I assume all risks and responsibilities thereof. I have obtained insurance to meet any and all payments for, or related to, medical costs that may arise during my participation in the Program. The College/Association is not responsible in any way for the cost, quality, terms and conditions of any medical or healthcare treatment rendered to me during the Program. I hereby agree to pay all expenses and fees, and hereby release the College/Association from any liability, relating thereof.
7. **Assumption of Risk and Release of Claims.** Knowing the risks described above, and in consideration of being permitted to participate in the Program, and the professional and educational enrichment and academic credit I will derive from the Program, I agree, on behalf of my family, heir(s), executor(s), assignee(s), and personal representative(s), to assume all the risks and responsibilities surrounding my participation in the Program. To the maximum extent permitted by law, I release and indemnify the County of Suffolk and the College/Association, and their officers, employees and agents, from and against any present or future claim, loss or liability for injury to person or property which I may suffer, or for which I may be liable to any other person, during my participation in the Program.

I have carefully read this Release Form before signing it. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. By signing below I acknowledge this agreement shall become effective only upon execution and shall be governed by the laws of the State of New York, which shall be the forum for any lawsuits filed under or incident to this agreement or to the Program.

X _____ _____
Signature of Student (Parent / Legal Guardian – check below) *Date*

☐ I (A) am the parent/legal guardian of the above Participant, (B) have read the foregoing Release Form, (C) am and will be legally responsible to the obligations and acts of the Student as described in this Release Form, and (D) agree, for myself and for the Participant, to be bound by all of its terms.

Suffolk
COUNTY COMMUNITY COLLEGE

MEDICAL HISTORY & CLEARANCE FORM

MEDICAL HISTORY

PARTICIPANT INFORMATION

NAME OF PARTICIPANT: _____

STUDENT ID: _____

D.O.B: _____ AGE: _____ ____ FEMALE ____ MALE

PROGRAM

_____

FAMILY DOCTOR

Name: _____

Address: _____

Phone: _____

PERSONAL AND FAMILY HISTORY (Please check / circle appropriate box for history of the following)

Self / Relative

- ☐ HEART ATTACK, STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ DIABETES
- ☐ CANCER
- ☐ ALCOHOL/DRUG ABUSE
- ☐ EMOTIONAL DISORDER
- ☐ HEREDITARY DISORDER

MAJOR SURGERY (attach additional pages as needed)

- ☐ Yes
- ☐ No

_____

_____

MEDICAL OR PSYCHIATRIC AID OR LONG-TERM COUNSELING OR BEEN HOSPITALIZED FOR EMOTIONAL PROBLEMS (i.e., emotional/eating disorders, drug/alcohol problems, etc. – attach additional pages as needed)

- ☐ Yes
- ☐ No

_____

_____

ON-GOING MEDICAL CONDITION AND/OR MEDICATIONS

- ☐ Yes
- ☐ No

_____

ALLERGY HISTORY

INHALANTS
- ☐ Yes
- ☐ No

FOOD INTOLERANCE
- ☐ Yes
- ☐ No

INSECTS
- ☐ Yes
- ☐ No

OTHER
- ☐ Yes
- ☐ No

DISABILITY OR CONDITION THAT MAY REQUIRE SPECIAL ACCOMODATIONS (i.e., first-floor housing, alternative transportation, etc. – attach additional pages as needed)

- ☐ Yes
- ☐ No

_____

_____

LEARNING DISABILITIES THAT REQUIRE SPECIAL ACCOMODATIONS (i.e., extended test time, separate testing room, etc. – attach additional pages as needed)

- ☐ Yes
- ☐ No

_____

_____

MEDICAL INFORMATION YOU WOULD LIKE TO DISCLOSE TO YOUR HOUSING/HOST FAMILY

- ☐ Yes
- ☐ No

_____

_____

LEARNING DISABILITIES THAT REQUIRE SPECIAL ACCOMODATIONS (i.e., extended test time, separate testing room, etc. – attach additional pages as needed)

- ☐ Yes
- ☐ No

_____

_____

CHILDHOOD ILLNESSES (i.e., extended test time, separate testing room, etc. – attach additional pages as needed)

CHICKEN POX
- ☐ Yes
- ☐ No

MUMPS
- Yes
- No

MEASLES
- ☐ Yes
- ☐ No

Physician/Healthcare Professional recommendation:

Based on the information provided to me by the participant and after a review of the participant's personal health history, I find that:

_____**There are NO medical or psychiatric contradictions** to participation, and the participant is cleared to study abroad.

_____**The participant is cleared to study abroad, BUT** program leaders should not the following medical information and needs:

Serious active or chronic condition:_____

_____

_____

Allergies:_____

Disabilities and Services needed:_____

_____

Critical Medication and Dosage taken (PLEASE, WRITE CLEARLY):_____

_____

_____

_____

_____**There ARE medical or psychiatric contradictions to participation**, and in my judgment the participant is NOT cleared to study abroad.

_____Signature of Physician/Healthcare Professional

_____Printed name of Physician/Healthcare Professional

_____Date

THE BELOW IS REQUIRED ONLY IF THE PARTICIPANT IS CURRENTLY BEING SEEN BY A SPECIALIST FOR SERIOUS ONGOING CONDITION:

_____Signature of Specialist

_____Printed name of Specialist

_____Date

_____Phone Number/Address

CLEARANCE FORM

IMMUNIZATIONS

I accept complete and absolute responsibility and liability for ensuring that I am properly immunized against conditions and diseases for the countries to which I am traveling. I represent and warrant that I am informed what the proper immunizations are for the countries. I further represent and warrant that I have confirmed with my physician and/or the U.S. Department of Health and Human Services – Centers for Disease Control and Prevention's website (wwwn.cdc.gov/travel/) for updates and recommendations regarding immunizations for the countries to which I am traveling. I further represent and warrant that I have received all necessary and recommended immunizations.

EMOTIONAL AND PHYSICAL STRESS

Living and studying in a foreign environment, as required by the Study Abroad program (the "Program") provided by Suffolk County Community College ("the College") may create unexpected physical and emotional stress, which may exacerbate otherwise mild disorders. I understand that it is important that I am able to adjust to dramatic changes in climate, diet, living conditions and studying conditions that may be disruptive to accustomed patterns of behavior. I understand that I should never assume that going abroad to study would provide an antidote to health problems experienced at home. I understand that if I fail to inform the College about a medical condition, medication or medical treatment that I have received/am receiving and there are related problems during the Program, it may result in my being dismissed from the program.

MEDICATIONS & TRAVELING ABROAD

If you regularly take prescription medications, bring a supply to last throughout your time abroad. Bring a letter (in your carry-on luggage) from your health care professional listing your medications, their dosage, their generic name, and a description of the condition being treated, and give your Program leader a copy of the letter upon arrival. This letter could be helpful in an emergency. Make sure all drugs you take with you are in the original pharmacy containers and are clearly labeled. You should carry copies of the prescriptions to avoid problems with Customs. Be sure to carry all prescriptions, medicines, and related paperwork in your carry-on luggage. In the case of narcotic medicines, you may not be able to carry additional supplies because of possible Customs difficulties. Instead, bring a prescription with the drug's generic name and a letter from your health care professional describing your condition. Most countries have very strict regulations on having medications shipped abroad, and in many countries it is illegal to ship it altogether. Check with the postal service and customs office well in advance. It is imperative that you discuss with your health care professional in the U.S. ahead of time how you will get medications that you need in your host country if you are not able to bring a full supply with you.

PARTICIPANT AUTHORIZATION & RELEASE

I authorize the College to seek and to obtain medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by duly licensed healthcare professional. I am aware that due to the nature of traveling abroad, it may not be possible to obtain the same quality of health care that I would receive if I were treated in the United States. I freely, knowingly and willingly choose to participate in the program and assume the associated risks and will take due care during such participation.

AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL INFORMATION

This authorization is requested by the Participant to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56, et seq. **I hereby authorize the release of information contained herein as the College deems necessary. I understand that this information will be used for the purpose of protecting participant's health during the term of the program identified on the form, or in the case of medical necessity while abroad**.

By signing below, I certify that the information contained herewith about my medical history is true and correct. Further I agree to be bound by all the terms and conditions presented herewith.

X _____ _____

Signature of Student (Parent / Legal Guardian – check below) *Date*

X _____

Printed Name (Parent / Legal Guardian)

□ I (A) am the parent/legal guardian of the above Participant, (B) have read the foregoing Release Form, (C) am and will be legally responsible to the obligations and acts of the Student as described in this Release Form, and (D) agree, for myself and for the Participant, to be bound by all of its terms.

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Suffolk
COUNTY COMMUNITY COLLEGE

AUTHORIZATION AND RELEASE FOR USE OF NAME, VOICE AND LIKENESS

I, _____, hereby grant Suffolk County Community College ("the College") irrevocable permission to use my name, voice, quotes, image, visual likeness, portrait, and photograph in all forms and media (including, but not limited to, publications, websites, catalogs, brochures, books, magazines, photo exhibits, motion picture films, and/or videos) (collectively referred to as "Works") for the following proposes:

1) Teaching;
2) Admissions applications;
3) Professional journal and papers;
4) Institutional publicity and public relations;
5) Archival purposes; and
6) Any other purpose which the College deems fit in the interest of education, knowledge, research, marketing, advertising, or public relations.

I agree that all right and title and interest in and to all such Works and any reproductions or derivative work thereof shall be the exclusive property of Suffolk County Community College. I understand that the College may keep or may use the Works and derivative works now and in the future.

I further consent to the use of my biographical material in connection with such photographs or other portraits or likenesses of me.

I agree that the College does not owe me any compensation for the acts I have consented to in this agreement.

I hereby release Suffolk County Community College, its officers, directors, agents and employees from all liability or legal responsibility that may arise from the acts that I have authorized or consented to herein.

I have carefully read and understand the terms and conditions of this Authorization and Release, and agree to be bound by them.

_____
Signature Date

_____
Printed Name

_____
(Signature of legal guardian is needed if subject is under age 18)

_____
Printed Name of Legal Guardian Date

Central Registrar
533 College Road
Selden, NY 11784-2899
(631) 451-4011

Ammerman Campus
533 College Road
Selden, NY 11784-2899
(631) 451-4110

Michael J. Grant Campus
Crooked Hill Road
Brentwood, NY 11717-1092
(631) 851-6700

Eastern Campus
121 Speonk-Riverhead Road
Riverhead, NY 11901-3499
(631) 548-2500