



SAIIE

"Your Life Experience; Your Education"

Medical Authorization and Consent Form

Student/Participant Full Name: _____

Date of Birth (DD/MM/YYYY): _____ / _____ / _____

Passport Number: _____

Program

- ☐ Semester Abroad
- ☐ Summer Program
- ☐ Winterim
- ☐ Gap Year Athletics Abroad
- ☐ Other: _____

Term Abroad in Sevilla: _____

Example: Fall 2027, Spring 2028, Summer 2027- Session I, Winterim 2027–28, Academic Year 2027–28

Athletic Program — Only if Applicable

- ☐ Swimming
- ☐ Rowing
- ☐ Volleyball
- ☐ Soccer
- ☐ Rugby
- ☐ Water Polo
- ☐ Beach Volleyball
- ☐ Other: _____

MEDICAL AUTHORIZATION

I authorize qualified and licensed medical professionals to provide medical evaluation, diagnosis, treatment, and emergency medical care to the above-named student/participant when, in the judgment of the attending medical professional, such care is necessary because of an injury, illness, or medical emergency.

If the student/participant is unable to provide consent at the time of an emergency, I authorize the attending medical professional to provide any medical treatment reasonably considered necessary to protect the student's/participant's life, health, or physical well-being, including medical examinations, diagnostic procedures, X-rays, medications, immunizations, and emergency or minor surgical procedures when medically indicated.



SAIIE

"Your Life Experience; Your Education"

I also authorize SAIIE staff members, faculty, guides, or other authorized representatives accompanying or supervising the student/participant to provide or arrange reasonable emergency assistance and to seek appropriate medical attention on the student's/participant's behalf prior to or during transportation to a medical facility, when necessary.

I understand that SAIIE staff and representatives are not medical professionals and are not authorized to diagnose or provide medical treatment beyond their training and qualifications. Their role is to provide reasonable assistance and facilitate access to appropriate medical care in an emergency.

This authorization applies throughout the student's/participant's participation in the SAIIE program, including program activities, excursions, travel associated with the program, and other activities organized or supervised by SAIIE.

AUTHORIZATION PERIOD

From: ____ / ____ / ____

To: ____ / ____ / ____
(Day / Month / Year)

ACKNOWLEDGMENT AND CONSENT

By signing below, I confirm that I have read and understood this Medical Authorization and Consent and voluntarily authorize medical care as described above.

STUDENT/PARTICIPANT

Student/Participant Name: _____

Signature: _____ Date (DD /MM/YYYY): ____ / ____ / ____

PARENT / LEGAL GUARDIAN CONSENT

Required only if the participant is under 18 years of age

Parent/Legal Guardian Full Name: _____

Relationship to Participant:

- ☐ Mother
☐ Father
☐ Legal Guardian
☐ Other: _____

Signature: _____ Date (DD /MM/YYYY): ____ / ____ / ____



SAIIE

"Your Life Experience; Your Education"

Email: _____

Phone: _____

EMERGENCY CONTACT

If different from the parent/legal guardian

Name: _____

Relationship to Participant:

- ☐ Mother
- ☐ Father
- ☐ Legal Guardian
- ☐ Other: _____

Phone: _____

Email: _____

For participants who are 18 years of age or older, the student/participant's signature is sufficient. A parent/legal guardian signature is not required.