Travel Abroad Release of Information Form

I, ______________________________, authorize Doane University to contact and release information
Name as it appears on passport
pertaining to all matters of my travel abroad to the persons listed below and authorize the parties listed below to contact and release information pertaining to all matters of my participation in study abroad to Doane University:

1. Parent Name(s)____
Address:____
Home Phone:______________________________ Business Phone: ____________________________
Mobile Phone:_____________________________ Fax______________________________________
Employer____ City____________________State _______

2. Additional Emergency Contact Name:____
Address:____
Home Phone:______________________________ Business Phone: ____________________________
Mobile Phone:_____________________________ Fax:_____________________________

3. Primary Physican:______________________________________Clinic:___________________________
City:_______________________________ State:___________ Phone:___________________________

4. Transportation Providers: Airline(s):____
Record Locator Number(s):______________________ Ticket Numbers:______________________________

5. Regular U.S. Health Insurance Information
Name of U.S. Health Insurance Company:____
Named of Primary Insured_______________________________________ Relation to you_______________
Policy Number:______________________ Company Phone______________________________________
Company Address____

6. Travel Health Provider Insurance Information:
Name of Travel Insurance Company:_________ ____
Name of Policy:____________________________________ Policy Number:_____________________________
Coverage Start date:______________ Coverage End Date:________________ Policy Number ______________________
Company Phone_____________________________ Company Website_____________________________________
Company Address____

7. The Doane Offices of International Programs, U.S. Department of State, Local Government Authorities, Admissions, Communication and Marketing, and the Doane community for promoting Doane study abroad programs.

I acknowledge that I understand the purpose of the request and that authorization is hereby granted voluntarily. I understand that this release is valid for a period of three hundred and sixty-five (365) days. I further understand that I may cancel or revoke this authorization at any time in writing. I certify that this form has been explained to me and that I understand its contents.

By my signature below, I consent to the release of information and documents.

Signature of Student	Printed Name of Student	Date of Authorization
Required Signature of a Witness	Printed Name of Required Witness	Date Signed