

SUNY MODEL E.U. 2012

Exeter University, UK

STUDENT/FACULTY ADVISOR REGISTRATION FORM

Registration Deadline November 10, 2011

THE CONFERENCE FEE IS \$125.00. STUDENTS AND FACULTY CAN PAY WITH A CREDIT CARD VIA FAX(MASTERCARD OR VISA) OR MAIL IN A CHECK.

MAKE CHECKS PAYABLE TO SUNY MODEL EU-CAS

C/O CHRISTINE WALDO-KLINGER

CONFERENCE SERVICES

SUNY NEW PALTZ

1 HAWK DRIVE-HAB 63

NEW PALTZ, NY 12561

FAX: (845) 257-3036

YOUR LAST NAME: _____

YOUR FIRST NAME: _____

GENDER:

MALE

FEMALE

HOME ADDRESS:

Street: _____

City/State/Country: _____

Postal Code: _____

COUNTRY OF RESIDENCE: _____

U.S. CITIZEN:

YES

NO

UNIVERSITY YOU ATTEND: _____

Are you coming alone, or with a delegation from that university? _____

E-MAIL ADDRESS: _____

REGISTRATION INFORMATION:

UPON RECEIPT OF PAYMENT, STUDENTS WILL BE ASSIGNED ALTER EGOS IN THE MODEL EU SIMULATION AND RELEVANT COUNTRY DELEGATION INFORMATION.

Conference Fee: \$125 for SUNY MEU (includes materials, 2 lunches, and opening and closing banquets, student mixer)

Please indicate if you require a vegetarian dinner option YES/NO

Lodging:

\$48 per student, per night in a double (one bed) or triple (2 beds) x 3 or 4 nights, (depending on arrival date) at Jury's Inn Exeter in Devon, UK. Students may elect to arrive on January 4 (the day before the simulation) or on Thursday, January 5 before 4 pm to arrive in time for the registration and opening ceremony.

Please indicate name of preferred roommate(s) as well, or if you would like us to find you a same sex roommate from another school.

Total Registration fees due: \$ 125.00
Lodging (\$48 x 3 or 4 nights) _____
(\$85 a night for faculty single)
Total Charge (lodging + registration)_____

Credit card information: Visa or Mastercard

Exp Date: _____

Signature: _____

Roommate Preferences: _____

Arrivals from U.S. and rest of Europe:

Arrival Date/Time (via train or air):

MEDICAL HISTORY

Physician's Name: _____

Address: _____

Telephone Number: _____

MEDICAL INFORMATION

1) LIST ALL KNOWN ALLERGIES: _____

Are You Allergic To Any Medications?

Yes

No

If So, Please List: _____

2) List All Medications Participant Will Be Taking During Stay:

3) Does Participant Administer His/Her Own Medication: [*If No: Attach Full Instructions As To The Time And Dosage Of Each.]

Yes

No

4) Does Participant Have Special Dietary Requirements: [*If yes: Explain Below]

Yes

No

Medical Agreement

I HEREBY AUTHORIZE THE MEDICAL SUPPORT STAFF OF THE STATE UNIVERSITY OF NEW YORK OR ANY EMERGENCY FACILITY TO ACT FOR ME ACCORDING TO THEIR BEST JUDGMENT IN ANY EMERGENCY REQUIRING MEDICAL ATTENTION.

I SPECIFICALLY UNDERSTAND THAT IEUSS, SUNYMEU AND THE STATE UNIVERSITY OF NEW YORK DO NOT PROVIDE ANY HEALTH INSURANCE COVERAGE FOR ME WHILE ENGAGING IN ANY EVENT ACTIVITY, OR PERFORMANCE.

I AM IN GOOD HEALTH AND ABLE TO UNDERTAKE THE EVENT, ACTIVITY, OR PERFORMANCE THAT I HAVE ELECTED TO PARTICIPATE IN FOR SUNYMEU.

I ACCEPT FULL RESPONSIBILITY FOR PAYING MEDICAL EXPENSES THROUGHOUT MY PARTICIPATION.

I HEREBY CONSENT TO FIRST AID, EMERGENCY MEDICAL CARE AND, IF NECESSARY, ADMISSION TO AN ACCREDITED HOSPITAL WHEN NECESSARY FOR EXECUTING SUCH CARE FOR TREATMENT FOR INJURIES I MAY SUSTAIN WHILE PARTICIPATING IN ANY EVENT, ACTIVITY, OR PERFORMANCE ASSOCIATED WITH SUNYMEU, INCLUDING TRAVEL.

Signature of Participant: _____

Date: _____

Birth date of Participant: _____

If the participant has not yet attained the age of 18 years, both parents (or legal guardians) of the above signed participant must also sign and date this form.

Signature of Participant's Father or Legal Guardian: _____

Date: _____

Signature of Participant's Mother or Legal Guardian: _____

Date: _____

MEDICAL INFORMATION FORM

Participant's Last Name: _____

First Name: _____ Age: _____

Gender: (Circle One) [Male] [Female]

Home Address: _____

City: _____ State: _____ Zip Code: _____

Country of Residence: _____

Medical and Emergency Contacts

Please provide contact names and numbers of two people. Name & address of person to contact in case of emergency: (should be the same as one from above)

Emergency Contact #1

Name: _____

Daytime Phone Number: _____

Evening (or cell) Phone Number: _____

Email address: _____

Emergency Contact #2

Name: _____

Daytime Phone Number: _____

Evening (or cell) Phone Number: _____

Email address: _____

Name of Medical Insurance Carrier: _____

Name of Insured: _____

Policy / I.D. #: _____

Agreement To Indemnify And Save Harmless

BY SIGNING BELOW, I AGREE TO INDEMNIFY AND SAVE HARMLESS THE STATE OF NEW YORK, THE STATE UNIVERSITY OF NEW YORK, THE INSTITUTE FOR EUROPEAN UNION STUDIES AT SUNY (IEUSS), THE SUNY MODEL EUROPEAN UNION (SUNYMEU), AND ALL OF THE OFFICERS, EMPLOYEES OR ASSOCIATES PARTICIPATING IN THE SIMULATION FROM ANY AND ALL CLAIMS, DEMANDS, SUITS, JUDGEMENTS, COSTS, EXPENSES, ACTIONS, AND CAUSES OF ACTION FOR PERSONAL INJURY OR INJURIES, DEATH OR LOSS OR DAMAGE(S) TO PROPERTY SUSTAINED BY THE UNDERSIGNED PARTICIPANT IN THE SUNYMEU 2012 PROGRAM, SPONSORED BY THE STATE UNIVERSITY OF NEW YORK, IEUSS, AND/OR THE CAMPUS AND/OR THE PREMISES, OF THE STATE UNIVERSITY OF NEW YORK AT NEW PALTZ, WITH PARTICULAR RESPECT TO THE SUNYMEU 2012 PROGRAM, SPONSORED BY THE STATE UNIVERSITY OF NEW YORK, IEUSS, SUNYMEU, AND RELATED ORGANIZATIONS.

Signature of Participant: _____

Date: _____

Birth Date of Participant: _____