

Return forms to: Katherine Richardson
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See Disability Services to request Accommodations!

HEALTH INFORMATION FORM

This form is to be completed by the participant

NAME _____ BIRTH DATE ___/___/___ GENDER _____

PROGRAM _____ OFFICIAL DATES OF PROGRAM _____ --- _____

The purpose of this form is to help the College be of maximum assistance to you should the need arise during your study abroad experience. Mild physical or psychological disorders can become serious under the stresses of life while studying abroad. It is important that the program be made aware of any medical or emotional problems, past or current, which might affect you in a foreign study context. The information provided will remain confidential and will be shared with program staff, faculty, or appropriate professionals only if pertinent to your own well being. The College may not be able to accommodate all individual needs or circumstances. This information does not affect your admission to the program.

MEDICAL HISTORY

Weight _____ Height _____

Yes ___ No ___ 1. Are you generally in good physical condition? (If no, please explain.) _____

Yes ___ No ___ 2. Have you ever been treated or are you currently being treated for any psychological or emotional problems? (If yes, please explain.) _____

Yes ___ No ___ 3. Do you have any allergies? (If yes, please explain.) _____

Yes ___ No ___ 4. Are you taking any medications? (If yes, please explain.) _____

Yes ___ No ___ 5. Have you had any major injuries, diseases or ailments in the past five years? (If yes, please explain.) _____

Yes ___ No ___ 6. Are you a vegetarian or are you on a restricted diet? (If yes, please explain.) _____

Yes ___ No ___ 7. Is there any additional information (concerning medical conditions or physical disabilities) that would be helpful for the program to be aware of during your study abroad experience? (If yes, please explain.) _____

I certify that all responses made on this Health Information form are true and accurate, and I will notify the College hereafter of any relevant changes in my health that occur prior to the start of the program.

Signature of Participant _____ Date _____