**HEALTH INFORMATION FORM/AGREEMENT**

Return to 950 Madison Avenue or scan/email to stroseglobal@gmail.com

**MEDICAL HISTORY**

The purpose of this form is to provide important health information to the Office of Global and Field Studies in order to assist you should the need arise during your travel abroad program. It is important that this office be made aware of any medical or emotional problems, past or current, which might affect you in a foreign trip context. The Office of Global and Field Studies and the program that you are participating in may not be able to accommodate all individual needs or circumstances.

Participant Name: Student ID:

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| **MEDICAL HISTORY** |
| Yes \_\_\_\_ No \_\_\_\_ 1. Are you generally in good physical condition? (If no, please explain.) |
| Yes \_\_\_\_ No \_\_\_\_ 2. Do you have any allergies? (Please explain.) |
| Yes \_\_\_\_ No \_\_\_\_ 3. Are you taking any medications on a regular basis? (Please describe) |
| Yes \_\_\_\_ No \_\_\_\_ 4. Have you ever been treated or are you currently receiving counseling for psychological or mental conditions (emotional problems, eating disorders, drug/alcohol, etc…)? (Please explain) |
| Yes \_\_\_\_ No \_\_\_\_ 5. Have you had any major injuries, diseases, or ailments in the past five years? (Please explain.) |
| Yes \_\_\_\_ No \_\_\_\_ 6. Are you a vegetarian or are you on a restricted diet? (Please explain.) |
| Yes \_\_\_\_ No \_\_\_\_ 7. Is there any additional information (concerning medical conditions or disabilities) that would be helpful for this office and the program to be aware of during your trip? If yes, Please explain. |

*I certify that all responses made on this Health Information Form are true and accurate, and I will notify the Office of Global and Field Studies hereafter of any relevant changes in my health that occur prior to the start of my study abroad program. I understand that the information provided will remain* ***confidential*** *and will be shared with program staff, faculty, or appropriate professionals only if pertinent to my own well-being. Failure to disclose pertinent health information may result in termination of my acceptance to study abroad prior to and during the program. Further, any costs related to any medical needs are my responsibility.*

Signature of Participant Date\_\_\_\_\_ / \_\_\_\_/\_\_\_\_\_

Name of Participant (PLEASE PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent (if student is under 18) Date\_\_\_\_\_ /\_\_\_\_/\_\_\_\_\_\_