



CONFIDENTIAL

Name: _____ Program: _____ Today's date: _____

Your health is an important component of your experience abroad. Because we want this experience to be positive, and because we want to be of help to you in case of sickness or injury, we ask that you complete this questionnaire as completely and as candidly as possible. Please keep in mind that your answers do not affect your status as a program participant. This information will remain confidential, to be shared with program staff only on a need-to-know basis, and will be deleted upon conclusion of the program.

- 1. Do you have a chronic health (physical or mental) condition? _____ If so, please describe this condition and your health management plan for when you are abroad.

- 2. Are you taking any medications? _____ If so, please identify the medication(s) and confirm with your physician that these medications are legal in your program country.

- 3. Do you have a health condition or disability that may require reasonable accommodations to fully participate in your program abroad? _____ If so, please describe this condition and consult with Student Disability Services about accommodation possibilities abroad. Note: While we will work to provide reasonable accommodations when they can be arranged, we cannot guarantee services or accommodations abroad.

- 4. Do you have any allergies (food, medication, etc.)? _____ If so, please elaborate.

- 5. Apart from any food allergies declared above, do you have any dietary restrictions? _____ If so, what are they? Some group meals may be arranged on your behalf, and it is important to share dietary restrictions with our on-site colleagues in advance. Please keep in mind, however, that not all dietary restrictions can be accommodated in all program sites. If you have concerns about this, please speak with your Program Coordinator.

- 6. Is there anything else in your medical history—illness or injury—about which it would be potentially useful for us to know (to ensure your full participation in the program)? _____ If so, please elaborate.

- 7. We would like to have permission to contact your parents in the event of a medical emergency abroad. Please sign your name here if you grant this permission.

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Thank you for completing this form. If you would like to elaborate on anything here or if you want to discuss health considerations outside the framework of these questions, please feel free to attach a sheet. You are always welcome to speak privately (and confidentially) with the Study Abroad staff about any question, potential medical problem, or concern.

- By my signature below I consent to the Study Abroad Office's use of this health information for the purposes of supporting my participation in the Study Abroad program. This information will be held in strict confidence, to be shared with program staff only on a need-to-know basis and will be deleted at the conclusion of the program.

Participant signature

Date

Printed name

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