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Study Abroad Participant Health Information

This form *must be completed and signed by the study abroad participant and, if appropriate (see below, part 5), by a physician or clinician*, and then returned, together with a photocopy, to the International Programs in Engineering (IPE) office. It is **due no later than six weeks before the study abroad program begins**. The information requested will allow the IPE office to better assist the participant should health concerns arise during the study abroad experience, and particularly in the event of a health emergency. Because mild, pre-existing health disorders can become serious under the stresses of life while studying overseas, it is important that a healthcare provider evaluate any conditions which might limit the participant's ability to successfully undertake the study abroad program. The IPE office will make every effort to accommodate health needs abroad and to ensure that suitable care is available. However, *some destinations may not be advisable for individuals with certain health conditions*. The information provided below may be shared with on-site program staff.

The **participant** should complete parts **1**, **2**, **3**, and **4**; the **participant's health care provider** (if applicable), part **5**.

1) Participant: ____ Program: _________________________ Term: ____________

2) In case of an emergency involving the participant during the study abroad period, the hosting institution may need to reach the student's family and/or regular health care provider, for whom the following information is requested.

Emergency family contact: _____________________________________ Relation to participant: ______________________

Address: ____ City: ___________________State: _________ Zip:___________

Phone number (daytime): ____________________________________ (evening): _____________________________________

Email address: ________________________________

Emergency family contact: _____________________________________ Relation to participant: ______________________

Address: ____ City: ___________________State: _________ Zip:___________

Phone number (daytime): ____________________________________ (evening): _____________________________________

Email address: ________________________________

Regular health care provider (personal physician, group practice, etc.): ____

Office phone number: ______________________________ Emergency phone number: ______________________________

3) *The participant must be covered adequately by health ("sickness and accident") insurance while attending an IPE office program.* It is important for the student to determine whether his/her current provider offers coverage abroad, to know the terms of coverage and reimbursement, and to obtain additional coverage as may be necessary. The IPE program participant is eligible for certain reimbursable--though by themselves insufficient--health insurance benefits through the purchase of the International Student Identity Card (ISIC).

Participant's insurance provider: ____

Participant's insurance policy or coverage number: ____

4) The participant is required to answer questions **a** through **d** below, attaching additional pages as needed; consider and respond appropriately to **4e**; and endorse the italicized statements immediately following. All responses are requested for the sole purpose of assisting program staff in meeting emergencies and any special health needs.

a. Will you require special accommodations or support services while abroad because of a disability (learning, visual, hearing, mobility, psychiatric) or other impairment? If yes, please provide verification of the disability from the Office of Services for Students with Disabilities, as well as a full description of what arrangements may be needed.

b. Do you have any drug, food, or other allergies? If yes, please identify them, your reactions if exposed, and the recommended treatment plans.

c. Do you have any dietary restrictions? If yes, please give details.

d. Do you regularly take medications? If yes, please identify them, and be sure to bring with you to your program site an adequate supply of each, in pharmacy-labeled containers.

e. If you suffer from, or have experienced, one or more of the following, you are *required* to be evaluated and cleared, in light of the relevant condition(s) or event(s), for participation in your IPE program by your health care provider(s), who must respond in part **5** below:

Alcohol/substance abuse	Anxiety disorder	Asthma	Bipolar disorder
Crohn's disease	Depression	Diabetes	Eating disorder
HIV/AIDS	Immunodeficiency	Obsessive/compulsive disorder	Schizophrenia
Severe migraine	Suicide attempt	Ulcerative colitis	Other chronic medical illness

All responses that I have given on this form and attached sheets are true and accurate to the best of my knowledge. I understand that failure to supply true and accurate information may result in my dismissal from the program. I will provide the International Programs in Engineering (IPE) office with the necessary clearance to participate if ***4e*** *applies to me. I will notify the IPE office of any relevant changes in my health that occur prior to the start of the program, and that may affect my ability to participate.*

Signature of participant affirming above statements   Date

5) To the health care provider: The individual presenting this form for signature suffers from, or has experienced, one or more of the conditions or events listed above, in **4e**, which may put her/him at higher risk while studying abroad. You are asked to evaluate the individual's health and respond below as appropriate. Please take into account that living and studying in a foreign environment frequently triggers unexpected physical and emotional stress, which can exacerbate otherwise mild disorders. It is important that the participant be able to adjust to potentially dramatic changes in climate, diet, living arrangements, social life, and study demands that may seriously disrupt accustomed patterns of behavior. Moreover, although health care in many places is readily available and of sufficiently high quality, the participant may be going to a location where treatment is difficult to obtain and/or less reliable. Especially for certain conditions, such as psychological disorders, the participant often will not have convenient, if any, access to the kinds of resources and support she/he may be dependent on at home.

On the basis of my knowledge of this student's health, I (please check language that applies)…

( ) find no medical or psychological contraindications to her/his participation in this study abroad program.

( ) recommend against this individual participating in ( ) this or ( ) any study abroad program.

( ) support this individual participating in this study abroad program, but only under the following conditions:

I have discussed my response above with the participant and have given appropriate counseling.

Signature of health care provider affirming responses in 5) above   Date   Printed name of health care provider