



Office of Study Abroad
 219 University Center
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 Flint, MI 48502-1950
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 Phone: 810-762-0867 Fax: 810-762-0006

HEALTH INFORMATION FORM

This form *must be completed and signed by the study abroad participant and, if appropriate (see below, part 4), by a physician or clinician*, and then returned, together with a photocopy, to the Office of Study Abroad (OSA) It is **due no later than six weeks before the study abroad program begins**. The information requested will allow the Office of Study Abroad to assist the participant more effectively 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 studying overseas, it is important that a healthcare provider evaluate any conditions which might limit the participant's ability to undertake the study abroad program successfully. The OSA 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.

Part 1: To be complemented by participant.

NAME		
First, Middle Initial	Last	UMID
PROGRAM INFORMATION		
Program Name	Term Participation	
	<input type="checkbox"/> Fall 20____ <input type="checkbox"/> Winter 20____ <input type="checkbox"/> Spring ____ <input type="checkbox"/> Summer ____	

Part 2: To be completed by participant. 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. *Note: It is advisable that the emergency contact have a passport in case of a medical emergency abroad.*

EMERGENCY FAMILY CONTACT			
Name (first, last)		Relationship to Participant	
Street Name and Number	City, State	Zip Code	
Email Address	Daytime Phone	Evening Phone	

EMERGENCY FAMILY CONTACT			
Name (first, last)		Relationship to Participant	
Street Name and Number	City, State	Zip Code	
Email Address	Daytime Phone	Evening Phone	

REGULAR HEALTH CARE PROVIDER	
Personal Physician Name (first, last)	Group Practice
Office Phone	Emergency Phone

Part 3: To be completed by participant. The participant is required to answer questions **3a through 3f** below, attaching additional pages as needed. Respond to **3e and 3f** and add any additional information that you think the OSA should know prior to your departure. Please endorse the italicized statements immediately following questions **3a through 3f**. All responses are requested for the sole purpose of assisting program staff in meeting emergencies and any special health needs.

<p>a. Will you require special accommodations or support services while abroad because of a disability (learning, visual, hearing, mobility, psychiatric) or other impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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. <i>Please note that neither the Rehabilitation Act of 1973 nor the Americans with Disabilities Act applies to overseas programs. The same level of accommodations you receive in the U.S. may not be provided to you abroad.</i></p>																
<p>b. Do you have any drug, food, or other allergies? If yes, please identify the allergies, your reactions if exposed, and the recommended treatment plans.</p>																
<p>c. Do you have any dietary restrictions? If yes, please give details.</p>																
<p>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.</p>																
<p>e. Have you been treated for any psychological or emotional problems at any time over the past five years? If yes, please explain.</p>																
<p>f. If you suffer from, or have experienced, one or more of the following, you are <i>required</i> to be evaluated and cleared, in light of the relevant condition(s) or event(s), for participation in your study abroad program by your health care provider(s), who must respond in part 4 below:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Alcohol/substance abuse</td> <td style="width: 50%;">HIV/AIDS</td> </tr> <tr> <td>Anxiety disorder</td> <td>Immunodeficiency</td> </tr> <tr> <td>Asthma</td> <td>Obsessive/compulsive disorder</td> </tr> <tr> <td>Bipolar disorder</td> <td>Schizophrenia</td> </tr> <tr> <td>Crohn's disease</td> <td>Severe migraine</td> </tr> <tr> <td>Depression</td> <td>Suicide attempt</td> </tr> <tr> <td>Diabetes</td> <td>Ulcerative colitis</td> </tr> <tr> <td>Eating disorder</td> <td>Other chronic medical illness</td> </tr> </table>	Alcohol/substance abuse	HIV/AIDS	Anxiety disorder	Immunodeficiency	Asthma	Obsessive/compulsive disorder	Bipolar disorder	Schizophrenia	Crohn's disease	Severe migraine	Depression	Suicide attempt	Diabetes	Ulcerative colitis	Eating disorder	Other chronic medical illness
Alcohol/substance abuse	HIV/AIDS															
Anxiety disorder	Immunodeficiency															
Asthma	Obsessive/compulsive disorder															
Bipolar disorder	Schizophrenia															
Crohn's disease	Severe migraine															
Depression	Suicide attempt															
Diabetes	Ulcerative colitis															
Eating disorder	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 Office of Study Abroad with the necessary clearance to participate if **3e or 3f** applies to me.*

I will notify the OSA of any relevant changes in my health that occur prior to the start of the program and that may affect my ability to participate.

SIGNATURES		
Student Name	Signature	Date

Part 4: To be completed by 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 **3e**, 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):

<input type="checkbox"/> Find no medical or psychological contraindications to her/his participation in this study abroad program. <input type="checkbox"/> Recommend against this individual participating in this or any study abroad program. <input type="checkbox"/> support this individual participating in this study abroad program, but only under the following conditions:
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I have discussed my response above with the participant and have given appropriate counseling.

SIGNATURES		
Name Health Care Provider	Signature	Date

Please submit the original form to the Office of Study Abroad (219 UCEN).