Creighton UNIVERSITY

10.2007

OFFICE OF INTERNATIONAL PROGRAMS

STUDY ABROAD

STUDY ABROAD HEALTH DISCLOSURE FORM

Complete all sections of this form. Incomplete forms will not be accepted. The information you provide is confidential, except in cases of illness or medical emergency. Answer all questions carefully; it is in your best interest to provide a candid evaluation of your health, stamina, and emotional stability. Submit completed forms directly to the Study Abroad Coordinator, Office of International Programs (OIP).

SECTION A: STUDENT INFORMATION

Last Name ______ First Name ______ M.I. ______ NetID ______ Date of Birth (mm/dd/yyyy) ____/____/____

Permanent Address ______ Street ______ City/State ______ Zip ______ Local or Cell Phone ____-____-____

CU Email ______ Academic Major(s) ______ Sex: ❑ Female ❑ Male

Ethnicity (optional): ❑ Native American ❑ Asian or Pacific ❑ African ❑ Caucasian ❑ Hispanic ❑ Multiracial ❑ Other: ______

SECTION B: STUDY ABROAD PROGRAM INFORMATION

Program Sponsor ______ Host Institution ______ City & Country ______

Departure Date (*dd/mm/yyyy*) ____/____/____ Return Date *(dd/mm/yyyy)* ____/____/____ Passport Number ______ Passport Expiration Date ______

SECTION C: EMERGENCY CONTACT INFORMATION

2 emergency contacts required, must have different phone & address

Contact #1: Last Name ______ First Name ______ Relationship ______

Street Address ______ City/State ______ Zip ______ Phone ____-____-____

Contact #2: Last Name ______ First Name ______ Relationship ______

Street Address ______ City/State ______ Zip ______ Phone ____-____-____

SECTION D: HEALTHCARE PROVIDER CONTACT INFORMATION

In the event that you are in need of medical treatment while abroad, the physician who is attending you in the host country may need to contact your primary care physician in the United States. Please supply the name and contact information for the healthcare provider that would have knowledge of your medical history. This may be CU Student Health, a healthcare provider in your area, or a childhood pediatrician.

Name of Physician ______ Clinic Name ______

Clinic Address ______ Street ______ City/State ______ Zip ______ Phone ____-____-____

SECTION E: MEDICATIONS

Will you need to take medications while you are abroad? ❑ Yes ❑ No

If yes, please list medications, reason for use, and frequency of use (attach additional sheet, if needed):

______

SECTION F: ALLERGIES

Are you allergic to any of the following? Mark “yes or no” for each…

❑ Yes ❑ No Aspirin
❑ Yes ❑ No Penicillin
❑ Yes ❑ No Sulfa
❑ Yes ❑ No Local Anesthetic
❑ Yes ❑ No Seafood/Shellfish
❑ Yes ❑ No Peanuts
❑ Yes ❑ No Dairy or Soy
❑ Yes ❑ No Gluten or Wheat
❑ Yes ❑ No Pet Dander
❑ Yes ❑ No Smoke
❑ Yes ❑ No Mold
❑ Yes ❑ No Pollen
❑ Yes ❑ No Dust
❑ Yes ❑ No Other: ______________________________

If you marked ‘yes’ to any of the above, please explain: ____

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____

____

SECTION G: REVIEW OF PAST ILLNESSES AND SYMPTOMS

❑ Yes ❑ No Has your physical activity been restricted during the past 5 years?

❑ Yes ❑ No In the past 5 years, have you consulted or been treated by mental health professionals, clinics, physicians or other practitioners (other than routine check-ups)?

❑ Yes ❑ No Do you have any health requirements or dietary restrictions?

❑ Yes ❑ No Have you ever been hospitalized or had a serious acute illness?

If you marked ‘yes’ to any of the questions above, please explain, including details regarding diagnosis and date, if applicable.

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SECTION H: EXISTING CONDITIONS AND ACCOMMODATIONS

❑ Yes ❑ No Do you have a medical condition that may, under stress and duress, require immediate medical attention during your participation in the study abroad program (heart condition, epilepsy, asthma, sickle cell, diabetes, etc.)?

❑ Yes ❑ No Do you have any physical or emotional conditions which may affect your participation in an off-campus program due to dietary restrictions or need for accessible transportation and housing?

❑ Yes ❑ No Do you have any conditions which may affect your emotional or mental well-being during your participation in the study abroad program?

If you marked ‘yes’ to any of the questions above, please explain and indicate any accommodations or support that may be needed while abroad:

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SECTION I: STUDENT SIGNATURE

By signing below, I acknowledge that the information I have provided on the Study Abroad Health Disclosure Form is accurate, to the best of my knowledge. In the event of an emergency, I authorize the OIP to share this information with my parents/guardians, the study abroad program sponsor or host institution, and the attending physician(s) overseas, unless I notify the OIP in writing otherwise.

____ ________/________/____________

Student Signature Today’s Date