

**OFFICE OF INTERNATIONAL PROGRAMS  
INDIVIDUALS TRAVELING 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: PARTICIPANT 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                      Sex:  Female  Male

Ethnicity (optional):  Native American  Asian or Pacific  African  Caucasian  Hispanic  Multiracial  Other: \_\_\_\_\_

**SECTION B: ABROAD PROGRAM INFORMATION**

\_\_\_\_\_  
 Program or Organization Abroad (if applicable)                      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...

- |                              |                             |                   |                              |                             |                 |
|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|-----------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aspirin           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gluten or Wheat |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penicillin        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pet Dander      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sulfa             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Smoke           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Local Anesthetic  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mold            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seafood/Shellfish | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pollen          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Peanuts           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dust            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dairy or Soy      | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: PARTICIPANT SIGNATURE

By signing below, I acknowledge that the information I have provided on the 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 program sponsor or organization, and the attending physician(s) overseas, unless I notify the OIP in writing otherwise.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date