Study Abroad Student Health Information

Please type or print in ink.

Name: _____
Last First Middle

Program: _____
Location Abroad Approximate dates of the program Administering SUNY

To the Student: The information provided will remain confidential. Be aware that you will be responsible for your own care, although your leaders will make every effort to provide assistance and travel with a list of nearby hospitals. Please be honest with yourself and prepare accordingly. The questions that follow will help guide you in preparing for your stay abroad. Indicating that you have health concerns may allow us to assist you in determining if you are prepared to go and can receive appropriate treatment.

1. Do you have or have you had any physical, psychological or emotional conditions (including eating disorders), that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? If yes, explain below and plan to see your health care provider to discuss your care.	☐ Yes	☐ No
2. Have you arranged to receive all the necessary immunizations and medications recommended for visiting the program site by reviewing information that: - may have been provided by SUNY or your faculty travel leaders - is available on the US Center for Disease Control and Prevention website; and - may be available from the government of the countries you will enter?	☐ Yes	☐ No
3. Do you have any allergies, reactions to medications, or dietary restrictions? If yes, consider what you may need to manage your condition or restrictions. **If needed, see your health care provider for assistance in planning for your care.** You may list any allergies or dietary restrictions below so we can inform overseas providers. However, SUNY can only inform and cannot ensure that you can be protected from exposure.	☐ Yes	☐ No
4. Are you currently taking or have you recently discontinued any medications you may need while abroad? If yes, list medication name and purpose below: Please consider how you will have access to the medication you need and consult with your physician to develop a plan for managing your condition while abroad. Depending on the medication, SUNY may request additional information.	☐ Yes	☐ No
5. ***(Disclosure of disabilities is optional)*** Do you have a disability for which you are seeking accommodations? If yes, provide a description of desired accommodations. Please be aware that the Americans with Disabilities Act (ADA) does not apply outside the borders of the United States. The Administering Campus will assist you, to the extent possible, to obtain the accommodations you may want; however, it may not be able to obtain the accommodations necessary to enable you to participate in all aspects of the overseas program. Continued on next page.	☐ Yes	☐ No

6. Person to notify in case of emergency, illness or accident:

Name: _____ Relationship to student: _____

Street/Apt #: _____ Daytime Telephone #: (_____)_____

City, State, ZIP: _____ Evening Telephone #: (_____)_____

E-mail Address: _____ Cell Telephone #: (_____)_____

Second person in the event that the above cannot be reached:

Name: _____ Relationship to student: _____

Street/Apt #: _____ Daytime Telephone #: (_____)_____

City, State, ZIP: _____ Evening Telephone #: (_____)_____

E-mail Address: _____ Cell Telephone #: (_____)_____

Student Declaration

I grant the State University of New York, its employees, agents and overseas partners permission to share information concerning my health condition with program representatives, my family, insurance company representatives and with any physician, psychologist or counselor who treated me during the past five years or is now treating me. In situations where I am unable to give oral or written consent, I grant permission for hospitalization and treatment recommended and carried out under the supervision of a qualified physician, including administering anesthetics and performing necessary surgery at my own expense. I appoint the representative of SUNY in the host country for the program to act on my behalf in authorizing necessary medical, dental or surgical care, hospitalization or medical evacuation for me should this be required.

I certify that all responses made on this form are true and accurate, and that **I will notify the Administering Campus hereafter of any relevant changes in my health that occur prior to the start of the program.**

_____

Student's Signature Date

_____

Parent/Guardian's Signature (required if student is under 18 years of age) Date

If you answered yes to 1, or 4, or no to 2 please make an appointment with your health care provider to review your medical history and travel plans and have him/her sign below.

To the Treating Clinician: Please review the student's medical history, discuss with him/her the upcoming overseas study plans and sign below. A physical exam is not required by SUNY if you have adequate information to advise the student.

I have reviewed this student's medical history and examination with him/her, consulted with him/her about vaccinations and medications that may be required, and developed a treatment plan for the student to manage his/her condition during the overseas program, if needed. (Attach pages as necessary.)

_____

Signature of Provider Printed Name of Provider

_____

Address, Phone Number and Stamp of Provider