HUNTER The City University of New York | *Division of Student Affairs Education Abroad*

HEALTH INFORMATION QUESTIONNAIRE

NAME_____ DOB_____ PROGRAM _____

The purpose of this form is to help HUNTER COLLEGE to be of maximum assistance to you should the need arise during your study abroad experience. Mild physical or psychological disorders can become serious under the stresses of life while studying abroad. It is important that the program be made aware of any medical or emotional problems, past or current, which might affect you in a foreign study context. The information provided will remain confidential; and will be shared with program staff, faculty, or appropriate professionals only if pertinent to your own well-being. HUNTER COLLEGE may not be able to accommodate all individual needs or circumstances. This information **does not** affect your admission to the program. Please note: the nondisclosure of a physical or medical condition may affect our ability to provide information relevant to your specific needs abroad.

MEDICALHISTORY

1. Are you generally in good physical condition? (If no, please explain.) Yes___No____

2. Have you ever been treated or are you currently being treated for any psychological or emotional problems? (If yes, please explain.) Yes___No____

3. Do you have any allergies to drugs or foods? (If yes, please list ALL) Yes___No____

4. Are you taking any medications? (If yes, please list ALL medications.) Yes___No____

5. Have you had any major injuries, diseases or ailments in the past five years? (If yes, please explain.) Yes___No____

6. Are you a vegetarian or are you on a restricted diet? (If yes, please explain.) Yes___No____

7. When was your last tetanus shot? _____

8. Is there any additional information (concerning medical conditions or mental, learning, or physical disabilities) that would require accommodation or be helpful for the program director to be aware of during your study abroad experience? (If yes, please explain.) Yes No

_____

_____

_____

I certify that all responses made on this Health Information Questionnaire are true and accurate, and I will notify HUNTER COLLEGE hereafter of any relevant changes in my health that may occur prior to the start of the program. I further understand that, in the event of an emergency abroad, HUNTER COLLEGE reserves the right to notify my parent(s), guardian, spouse, or designated agent (if not a minor). By signing this form, I give consent for all Hunter College/CUNY staff and faculty who are directly administering my program to view this information for awareness, and in the case of an emergency, to share it with any medical professionals involved in my care.

_____ _____

SIGNATURE OF PARTICIPANT DATE

_____ _____

SIGNATURE OF PHYSICIAN DATE

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PHYSICIAN'S STATEMENT

TO THE APPLICANT: Please authorize by your signature below the release of any medical information that may be relevant in the opinion of your physician to your participation in the study abroad program.

_____

Your name *Program name and location*

Application for: Spring 20_____Fall 20_____Summer 20_____Intersession 20_____Academic Year 20__ - 20____

_____

Length of term away

_____

Signature Date

TO THE PHYSICIAN: Please indicate if the student named above has a history of chronic or disabling physical conditions; any allergies which may require either continuing or emergency treatment; any special dietary problem; or any other physical or emotional condition which might affect his/her well-being or that of fellow students while living or traveling outside the United States for an extended time. Please list the generic names for any prescription medicine the student requires which may not be readily obtainable abroad.

Physician's Name (print):

_____

Address:

_____

Signature:_____ Date: _____

A DOCTOR'S STAMP AND/OR LICENSE # IS REQUIRED

NOTE: An extension may be provided up to 30 days from application deadline date for submission of physician's forms if necessary. Please hand in the rest of the application as soon as possible.