

CASPER COLLEGE INTERNATIONAL EDUCATION OFFICE

HEALTH INFORMATION FORM

Note: The purpose of this form is to provide important health information that can be used to assist you should the need arise during your study abroad program. It is important that we be made aware of any medical or emotional problems, past or current, that might affect you in a foreign country. The information provided will remain confidential and will be shared with program staff, faculty, or appropriate professionals only if essential to your own well-being. Providing the information requested is not absolutely mandatory, but your refusal to do so could be potentially harmful since the U.S. system of health care is unlikely to be replicated abroad. Please consult with your regular physician in completing this form.

Student's Name _____ **Date of Birth** _____

Please provide contact information for your primary health care provider. (This information will only be used in an emergency.)

Doctor's Name _____ **Office Telephone** _____

Cell Phone _____ **e-mail address** _____

Medical History

Yes ___ No ___ 1. Do you have any chronic health problems such as asthma, diabetes, epilepsy, depression, bipolar disorder etc.? If yes, please list any problems, even if they are currently controlled by medication.

Yes ___ No ___ 2. Do you have any allergies? If yes, are you taking any specific medications? If yes, please list.

Yes ___ No ___ 3. Have you ever been treated or are you currently receiving counseling for psychological or mental conditions (emotional problems, eating disorders, drug/alcohol etc.) If yes, please explain.

Yes ___ No ___ 4. . Are you taking any prescription medications on a regular basis? If yes, please describe.

Yes ___ No ___ 5. Have you had any major injuries, diseases, or ailments in the past five years? If yes, please explain.

___ Please provide any additional information (concerning medical conditions or disabilities) that would be helpful for this program to be aware of during your travels.

I certify that all responses made on this Health Information Form are true and accurate, and I will notify the International Education Office of any relevant changes in my health that occur prior to traveling abroad.

Name of Participant _____

Signature of participant _____

Date _____

If student is under 18, a parent's signature is required as well.

Signature of Parent _____

Date _____