



Before you go: *Things to do to protect your health*

1. Call your primary medical provider or Campus Health and make an appointment. When you call Campus Health, please indicate that you simply need to have a physician or nurse practitioner review your *Study Abroad Health Information Form*. You will also need to discuss any health needs and services you will require abroad including vaccinations and an adequate supply of medications. The need for a physical exam will be left to the medical provider and the patient's discretion and is not required for the purposes of completing this form.
2. Read thoroughly and complete the following Health Information Form and sign where indicated.
3. Educate yourself about current health issues where you will be going and regarding available medical services. Please see the following websites and inquire with your Study Abroad advisor regarding recommended vaccinations and travel precautions:
Center for Disease Control: <http://wwwn.cdc.gov/travel/default.aspx>
State Department: <http://travel.state.gov>
UA Travel Clinic:
http://www.health.arizona.edu/webfiles/health_services_immunizations.htm
4. Review your current medical insurance coverage – if it does not provide international coverage, obtain a new policy that covers you abroad. The plan should include medical evacuation, repatriation and hospitalization. Take into consideration any special medical needs you have when obtaining medical insurance. Those with chronic health conditions should obtain coverage that includes pre-existing conditions. Please stop by the Office of Study Abroad and Student Exchange (SASE) if you would like a sampling of insurance providers that may be able to provide you with this coverage.
5. Once you are accepted to your study abroad program, you may need an appointment with the Campus Health Service Travel Clinic (621-2292) to consult on the need for tests, medications and immunizations. Your regional choice may require additional guidance on the possible health risks associated with your destination (e.g. malaria, diarrhea, hepatitis A or B, typhoid fever, yellow fever, meningitis, encephalitis, tuberculosis, etc.)
6. Keep a copy of this Health Information Form to take abroad to give to your Program Director or homestay provider in the case of an emergency.
7. If you are a student with a disability requesting accommodations for your Study Abroad/Exchange experience you will need to register with the sponsoring institution's disability resources. If you are attending a UA sponsored program please contact Disability Resources at (520) 621-3268, uadrc@email.arizona.edu.

I have carefully read all of the points above and have completed all of the steps recommended:

_____/_____
Signature of Student / Date



HEALTH INFORMATION FORM

Instructions

To the Student:

To ensure your well being while overseas, we ask that all UA students planning to study abroad complete the following health information form and return it to SASE with your program application. Please read the following questions carefully, paying close attention to detail. Failure to provide complete and accurate information on this form may result in the termination of your participation in the program. If you have any questions, please contact your Study Abroad advisor or SASE at 520-626-9211.

RELEASE OF INFORMATION: I authorize the release of information in this report, as well as any other medical information the undersigned medical provider believes to be relevant to my study abroad experience, to SASE and to the coordinators of the program overseas in the case of faculty-led programs. I acknowledge and agree that nothing in the foregoing statement or authorization to release information shall be construed as creating any obligation or duty on the part of UA to obtain medical care on my behalf.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I may revoke this release at any time by providing written notice of such revocation to SASE, except to the extent that action based on this authorization has already been taken This authorization is good for one year from the date I sign this release.

_____/_____
Signature of Student / Date

(Important: If the participant is under 18 years old, the parent or legal guardian must also sign below)

_____/_____
Signature of Parent or Legal Guardian / Date

To the Student’s Medical Provider:

Travel overseas to work or study can be associated with risks to health not seen in the United States, as well as decreased access to medical care and services. The patient you are seeing today is applying for a program of study outside of the United States. The need for a physical exam will be left to the medical provider and the patient's discretion and is not required for the purposes of completing this form. But please review their medical history and discuss with them any health care needs they have that may be impacted by their time overseas, including any health risks in their destination country that may pose a significant risk for them. Your signature below (page 4) indicates that you have reviewed the UA Study Abroad Health Form and that this discussion has occurred.

Thank you,

University of Arizona Office of Study Abroad and Student Exchange (SASE)
Tel. 520 626-9211



HEALTH INFORMATION FORM

questionnaire

LAST NAME _____
FIRST NAME _____
BIRTH DATE MM/DD/YY ____/____/____ MALE _____ FEMALE _____
UA STUDENT NUMBER _____
PROGRAM NAME _____
TERM AND YEAR _____

GENERAL HEALTH (check off or circle items that apply)*

My general health is: Excellent _____ Good _____ Fair _____ Poor _____

Allergies: Penicillin _____
Aspirin _____
Peanuts _____
Eggs _____
Bee stings _____
Pollen (hay fever) _____
Other (give details) _____
Dietary restrictions if any: _____

Devices: Contact lenses _____
Corrective lenses (eyeglasses) _____
Hearing aid R _____ L _____
Prosthetic joints or devices (give details) _____
Other (give details) _____

MEDICAL HISTORY

Do you have a history of any chronic illness such as asthma, diabetes, high blood pressure, anxiety, depression, etc.? Yes ___ No ___ If Yes, please list:

Have you had any major surgery in the past? Yes ___ No ___ If Yes, please give the dates and type:

Have you ever been hospitalized? Yes ___ No ___ If yes, please give the dates and

Reason: _____

Mental Health Treatment: Have you been treated by a physician, psychiatrist, psychoanalyst, psychologist, or therapist for any mental, emotional, or nervous disorder within the past 5 years? Yes _____ No _____

Do you have a history of emotional disturbance, such as: difficulties in relations with parents, authority figures or peers; symptoms indicating mood swings, depression, severe sleep disorders, unusual degree of anxiety, fear, or guilt?* Yes ___ No ___

Do you have any predisposing medical, surgical, or emotional factors which you think may under stress or duress during the program present a need for immediate attention while abroad? Yes ___ No ___

If the answer to any of the questions above is "Yes", please elaborate in a separate, signed note.

Please list and describe all prescription medications you are presently taking and their dosage:



HEALTH FORM

Signatures

STUDENT STATEMENT: The answers I have given are correct and true to the best of my knowledge. I acknowledge and agree that failure to include relevant health information in this report could lead to my separation from the program. I also acknowledge and agree that I may be required to be evacuated or removed (temporarily or permanently) from the program in the event that a medical condition leads medical professionals, the Program Director and/or the Director of SASE to consider it necessary.

_____/_____
Signature of Student / Date

(Important: If the participant is under 18 years old, the parent or legal guardian must also sign below)

_____/_____
Signature of Parent or Legal Guardian / Date

STUDENT AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT: I hereby authorize the faculty/advisor and/or attending physician to seek emergency treatment on my behalf if, in their opinion, emergency treatment is necessary to safeguard my health. I acknowledge and agree that nothing in the foregoing statement or authorization to release information shall be construed as creating any obligation or duty on the part of UA to obtain medical care on my behalf. I agree to pay for any charges for emergency medical treatment that are not covered by my personal health insurance.

_____/_____
Signature of Student / Date

(Important: If the participant is under 18 years old, the parent or legal guardian must also sign below)

_____/_____
Signature of Parent or Legal Guardian / Date

MEDICAL PROVIDER STATEMENT: I have reviewed the medical questionnaire responses provided by the student in this form and have discussed with this patient any health care needs they have that I believe may be impacted by their time overseas, including any health risks in their destination country that may pose a significant risk for them.

_____/_____
Signature of Medical Provider / Date