STUDY ABROAD HEALTH REPORT AND RELEASE

Traveling and living abroad presents physical and psychological challenges. Even mild problems may be exacerbated by the stress associated with adjusting to a new cultural environment. If you are not in good physical and emotional health, you should carefully consider your plan to go abroad at this time. If you have any questions about your situation, contact the Arkansas State University Study Abroad Office at (870) 972-3734 or the faculty member sponsoring or leading your program.

Consent for Release of Health Disclosure Form and for Medical Treatment Authorization

Please answer the questions contained in this form as honestly and completely as possible. It is very important that all sections are completed fully and accurately, as this will assist health care providers should you require medical attention or counseling services during your Study Abroad program. The information provided will be treated confidentially. However, you agree that this information will be used by Study Abroad personnel and provided to your faculty program leader to make them aware of any special medical needs that you may have or medical issues that may affect your participation in the program. In addition, the Study Abroad Office offers a CISI Study Abroad Medical Plan that enables you to: (1) check what medical facilities are available on the program's site(s); (2) make medical appointments on-site if medical care will be needed during the program; and (3) send medical records to a medical care provider overseas prior to departure.

- By accepting below, I hereby give my permission for Study Abroad personnel to release my health disclosure form to the Student Health Center, the Counseling Center at Arkansas State University, and to my faculty program leader. I understand that this information will be shared only when necessary for my own or others' health and safety or to be sure arrangements can be made to meet my needs.

- In the event of illness, injury, or other medical emergency, I hereby grant Arkansas State University or any of its representatives, full authority to take any action deemed necessary to protect my mental or physical health and safety, at my expense, and to secure necessary treatment, including placing me under the care of a doctor or in a hospital or any place for medical examination or treatment, the administration of an anesthetic and surgery, and the administration of medication as may be prescribed by a doctor. I further agree that I may be returned to the United States at my expense. I agree that if Arkansas State University makes any payments on my behalf, I will reimburse the University regardless of whether I deem the payments to be medically necessary. I hereby assume all responsibility for all medical expenses that I may incur while abroad including the costs of my evacuation or return for medical or other reasons. I authorize Arkansas State University to contact my parents or guardians about my physical or mental health while I am abroad if the University deems it advisable to do so.

- I understand and agree that Arkansas State University is not obligated to secure or pay for medical treatment on my behalf and cannot guarantee the quality of any such treatment. I hereby release Arkansas State University or the State of Arkansas, and their respective directors, officers, employees and agents from any and all liability, claims and causes of actions that might arise as a result of the exercise of their authority under this agreement.

- I certify that all responses made on the Study Abroad Health Self-Disclosure Form are true and accurate, and that I will notify the University of any relevant changes in my health that occur prior to or during the term of the program. I understand that this form is for information purposes only and in no way obligates the University or Program Leader to take any responsibility for my health.

- I have read and understand this document and agree that it will legally bind me and my estate, and I sign it voluntarily.

_____

Student Signature & Date

If the participant is under eighteen (18) years of age, this document must be signed by both the student above and on behalf of the participant by his or her parent or legal guardian. I have read and understand this document, I understand and agree that it will legally bind me and my estate, and I sign it voluntarily.

_____

Parent's or Guardian's Signature & Date

_____

Printed Name

_____

Relationship to Participant (Parent or Guardian)

STUDY ABROAD HEALTH SELF-DISCLOSURE FORM

If you answer "yes" to any of the questions below, or if there is any additional health information that would be helpful for us to be aware of during the program, please describe in the designated spaces. Use a separate sheet if necessary.

Sex: Male □ Female □

1. Do you have physical limitations? Yes □ No □

2. Have you or are you currently being treated for any psychological or emotional condition? Yes □ No □

3. Are you currently taking any prescription medications? Yes □ No □

4. Do you anticipate needing any health care or counseling while abroad? Yes □ No □

5. Do you have any dietary restrictions? Yes □ No □

6. Do you have any allergies to food, medicines, plants, or animals? Yes □ No □

7. Do you have a health condition including but not limited to?:
- Epilepsy or other seizure disorders Yes □ No □
- Asthma Yes □ No □
- Cardiac or circulatory problems Yes □ No □
- Respiratory problems Yes □ No □
- Arthritis or any other muscular or skeletal problems Yes □ No □
- Neurological problems or disorders Yes □ No □
- Bleeding disorders Yes □ No □
- Other Yes □ No □

Allergies:

Medications:

Explanation(s):

If you may require additional accommodations or considerations due to a medical condition/disability, please provide information:

Name _____ Signature _____

Forms have been adapted with written approval from Townson University