EMU Intercultural Programs

HEALTH INFORMATION FORM

INTERCULTURAL PROGRAM LOCATION _____ TERM/YEAR_____

Student Name: _____ Birth date: _____

Phone: _____ EMU ID #: _____

Parent/Guardian Name: _____ E-Mail: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone: _____

Secondary Phone: _____

Alternate contact (if no answer above):

Name: _____ Phone: _____

PART 1

Self-Assessment Checklist Questions

1. Do you have any disabilities for which you will need accommodations abroad?	Yes ☐	No ☐
If yes, are you registered with your institution's office that supports students with disabilities? If no, register today.	Yes ☐	No ☐
2. Do you have any serious food, drug, animal, insect, or other allergies?	Yes ☐	No ☐
If yes, are your symptoms life-threatening?	Yes ☐	No ☐
3. Are you on a medically restricted diet?	Yes ☐	No ☐
4. Do you plan to take prescription medications while abroad?	Yes ☐	No ☐
5. Have you been treated in the last **five** years, or are you currently being treated for any of the following conditions?	Yes ☐	No ☐
• General: Alcohol/Substance abuse, Eating Disorder, Immunodeficiency, Severe Migraine, Seizure Disorder, recent head injury or concussion	Yes ☐	No ☐
• Respiratory: Asthma, Tuberculosis	Yes ☐	No ☐
• Gastrointestinal: Crohn's Disease, Ulcerative Colitis	Yes ☐	No ☐
• Infectious Diseases: HIV/AIDS, Hepatitis	Yes ☐	No ☐
• Endocrine: Diabetes	Yes ☐	No ☐
• Mental health: Anxiety Disorder, Bipolar Disorder, Depression, Obsessive Compulsive Disorder	Yes ☐	No ☐

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PART 2

Action Steps Based on Answers to Part One

Please select the statement that applies to you:	
☐	I have answered no to questions #1–5 in Part One, and believe that no additional action on my part is necessary to safeguard my health abroad.
☐	I answered yes to one or more of questions #1–4 in Part One and will discuss my health care needs with one or more of the following: the Intercultural Program Leader(s), a representative from the Intercultural Programs Office, a representative from my home institution's disability services office, a representative from the program provider or host institution, a health care professional, parents, or other family members well in advance of my departure date. I acknowledge that leaders may ask for further information about these disclosures.
☐	I answered yes to question #5 in Part One and understand that I must: a) Submit Part Three to the applicable unit coordinating my program after having it completed by the physician providing care for my indicated condition or by another physician qualified to advise on my care. b) Sign a release form with my healthcare provider if I would like my provider to share relevant information with the appropriate unit coordinating my program. I acknowledge that leaders may ask for further information about these disclosures.

PART THREE: HEALTH ASSESSMENT FORM

Healthcare Provider Evaluation

(only required for students who answered "yes" to question #5 on self-assessment checklist: Part One.)

All students who answered yes to question #5 on the Self-Assessment Checklist: Part One must meet with a healthcare provider and submit this completed and signed form at least 6 weeks prior to departure.
The student should bring Part One and the appropriate pages from the CDC Travelers' Health website (see below) to the doctor's appointment.

STUDENT NAME and E-MAIL ADDRESS:

PROGRAM:

To the healthcare provider: Thank you for taking the time to meet with this student and complete this form. The student has been treated for one or more of the conditions or events listed in the Self-Assessment Checklist Part One, Number 5, over the past five years. Living and studying in an unfamiliar environment can trigger physical and emotional stress and exacerbate current health issues. Familiar or reliable healthcare or medications might not be readily available to the student in his/her host country.

You are asked to:

- Review any relevant information provided on the CDC Travelers' Health website for all countries on the student's itinerary. (See http://wwwnc.cdc.gov/travel/destinations/list.htm).
- Discuss the student's medical situation with him/her/them in light of how it may affect the student's international experience.

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- Ask the student about their destination and the demands of the specific program/experience as well as other countries they might visit that could pose health challenges.
- Advise the student regarding how potentially dramatic changes in climate, diet, living arrangements, social life, and study demands may affect him/her/them abroad.
- Discuss possible accommodations the student should make or discuss with staff administering or overseeing their travel program/experience.

To be completed by healthcare provider:

I have met with the student to discuss their medical condition as it relates to their intended international experience.

I have encouraged the student to discuss their medical condition with one or more of the following: a representative from the unit coordinating their program, a representative from the disability services office, a health care professional, a representative from the program provider or host institution, parents, or other family members well in advance of the program's departure date.

_____ _____

NAME OF MEDICAL PROFESSIONAL TITLE

_____

CITY/STATE

_____ _____

SIGNATURE DATE

Please read carefully and sign.

I/we have fully and completely provided all information requested above and have disclosed all health conditions that might in any way impact my ability to participate in this program and that except as noted above, I/we confirm that I am in good health and have the physical and mental ability to participate in this program. I/we understand that any information withheld or incomplete relieves EMU from all medical and legal liability and may also disqualify me from participation in this intercultural experience. I understand EMU reserves the option to dismiss a student whose mental or physical health requires care or supervision which cannot be adequately provided on site with the intercultural group.

I/we authorize the release and exchange of physical and mental health information including record of immunizations, as may be pertinent to participation in this intercultural experience between the EMU Health Center, EMU Counseling Services, the faculty leaders, and the EMU Intercultural office.

In the event of my sickness or injury, I/we hereby authorize the EMU intercultural leader to secure whatever treatment is deemed necessary, including the administration of an anesthetic and surgery or similar invasive procedure and release EMU and its employees, officers and trustees from any claim arising out of or related to, any such treatment or medical services provided.

I/we accept full financial responsibility for any medical costs not covered by insurance, incurred during the intercultural program.

_____ _____

Student signature *Date*

_____ _____

Parent/guardian signature if student is under age 18 (for domestic travel) *Date*