 **WLU Study Abroad Medical Questionnaire**

Because studying abroad can be both physically and emotionally demanding, we ask that you provide a candid evaluation of your health. A certain amount of stress due to culture shock or living conditions and facilities can be expected. In some cases, this may aggravate disabilities or illnesses which you have under control at home, or trigger onset of a previously undiagnosed condition.

This information will be used to guide us in making appropriate arrangements, as needed, for you. The information will be forwarded to the program director or coordinator abroad. Additionally, we hope completion of the form will create an awareness on your part of any health issues that you should take into consideration before going abroad. This information will NOT be used by West Liberty University to make any independent medical assessment of your condition or abilities. Such assessments are the sole responsibility of your health care providers.

**Instructions:** Please read each question below and answer either **YES** or **NO.** If you answer YES for any question, please provide additional information as requested.

1. Are you aware of any medical conditions – including but not limited to chronic illnesses, allergies or food intolerances – that may need to be treated or addressed during your participation in this program?

a)  Have you discussed with your health care provider a treatment or management plan for the period of time that you will be abroad?

b)  What arrangements might the Study Abroad Program need to make on your behalf for treatment or manage- ment of this condition?

c)  If you are studying in a non-English-speaking country, do you know how to describe your condition in the host country language?  If not, do you have a written description of your condition in your host country language to present, if needed, while abroad?

1. Have you had any major surgical operations, illnesses or injuries requiring hospitalization or emergency room treatment? If YES, please provide the following information:

Date Description Outcome/Present Condition

3. Have you ever been treated for any psychological/emotional problems?

 If yes, please list the dates.

 Does your condition require treatment or medication? If Yes, please list.

4. Do you have a documented disability as defined by the Americans with Disabilities Act? If yes, please state the nature of the disability:

In which areas does your disability currently impair your ability to perform daily academic activities?

Will you be requesting any accommodations during your study abroad program for the above listed disability?

5. Will you be taking any prescription medications while you are abroad? If yes, please list

Name of medication(s), dose, and instructions: (Attach additional sheet if necessary.)

Have you discussed with your physician how you will obtain a supply of these medications when you are overseas?

*NOTE: Some medications that can be legally prescribed in the U.S. are considered controlled (illegal) substances abroad. Alternate medications may need to be considered by your physician*

6. Are you up-to-date on all routine immunizations, including tetanus?

*Please visit the Centers for Disease Control and Prevention web site for information about immunizations that may be required or recommended for people traveling to the country where you will study abroad. http://wwwnc.cdc.gov/travel/default.aspx*

Are any immunizations required or recommended for travel to your program site abroad?

7. Medical History/Current Conditions

Please check all that apply and provide details below.

|  |  |  |
| --- | --- | --- |
| \_\_\_\_ Allergies of any kind \_\_\_\_ Anaphylactic Shock \_\_\_\_ Asthma \_\_\_\_ Cancer or tumors \_\_\_\_ Head injury\_\_\_\_ Thyroid problems\_\_\_\_ Colitis\_\_\_\_ Diabetes\_\_\_\_ Eating Disorder\_\_\_\_ Psychological/emotional /psychiatric condition | \_\_\_\_ Epilepsy or seizures \_\_\_\_ Frequent indigestion or ulcer \_\_\_\_ Heart or circulatory complications \_\_\_\_ Chronic respiratory problems \_\_\_\_ Chronic digestive/g.i. problems \_\_\_\_ Jaundice/hepatitis \_\_\_\_ Tuberculosis \_\_\_\_ Menstrual problems \_\_\_\_ Dizziness/fainting spells \_\_\_\_ Reaction to antibiotics | \_\_\_\_ Recent gain of weight \_\_\_\_ Recent loss of weight \_\_\_\_ Skin disease \_\_\_\_ High blood pressure\_\_\_\_ Trouble with eyes, ears, nose, or throat\_\_\_\_ Liver or gall bladder problems \_\_\_\_ Venereal disease \_\_\_\_ Narcotic/alcohol dependency \_\_\_\_ Other: |

Please provide details for any information checked above:

8. Are there any other concerns regarding your health, family history or other matters that you would like to discuss with a Study Abroad Advisor before your program begins?

If YES, please elaborate:

By signing below, I certify that the above information is true to the best of my knowledge. I release and hold harmless the State of West Virginia, the West Liberty University Board of Governors, and the University (including its officers, employees, and agents) from any claims. I understand that this form will be released to the faculty director of my study abroad program and other program staff as needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of applicant

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of applicant (printed)

|  |
| --- |
| Emergency Contact Information for Parent or Legal Guardian: |
| Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (street) (city) (state) (zip)Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Physician Contact Information: Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (street) (city) (state) (zip) |

On page 3, edit the 2nd sentence in the last paragraph so it reads, "...release and hold harmless the State of West Virginia, the West Liberty University Board of Governors, and the University (including its officers, employees, and agents) from any claims..."