Medical Self-Disclosure Form

Traveler Information

First Name*

Last Name*

Date of Birth* Please use this format: [MM/DD/YYYY]

Sex* (Select: male, female, other)

Acknowledgments and Authorization for treatment

I recognize that while abroad, an emergency may arise which requires medical care, hospitalization, or surgery. In the event of injury or illness, I hereby authorize the Youngstown State University representative or the hospital abroad to secure necessary treatment, including the administration of an anesthetic and surgery, and/or medication as needed, at my expense.

Yes, I understand, authorize and agree.*

- o Yes
- o No

I further agree that if my condition so requires, I may be returned to the United States, at my expense. *

- o Yes
- o No

I understand that mild physical and/or psychological disorders can become serious under the stresses of travel and study abroad. *

- o Yes
- o No

I understand that it is important that the program be made aware of any medical and/or emotional problems, past and current, which may affect me while abroad. *

- Yes
- No

I understand that the information I provide on this form will remain confidential and will be shared with program staff, faculty, and/or appropriate on-site professionals ONLY if pertinent to my own well-being. *

- Yes
- No

I understand that Youngstown State University representatives may not have the ability to accommodate all individual needs and circumstances while a student is abroad. *

- Yes
- No

Medical history

Are you generally in good physical condition? *

- Yes
- No

If not, please describe your condition(s). *

Have you ever been treated, or are currently being treated, for any psychological or emotional difficulties? *

- Yes
- No

If yes, please describe your condition and dates of any treatment. *

Do you have any allergies (food, medication, animal, environmental, etc.)?*

- Yes
- No

If yes, please describe your condition and your response to an allergic reaction. Please indicate whether exposure to the allergen could be life-threatening. *

Are you taking any medication(s)? *

- Yes
- No

If yes, please list the medication(s).*

If yes, I understand that it is my responsibility to discuss my study abroad program with my physician and to ask my physician to confirm that I can obtain my medication abroad and if it is legal to carry the medication in my host country.*

- Yes
- No

Have you had any major injuries, diseases or ailments over the past five years?*

- Yes
- No

If yes, please describe and list dates.*

Do you have any dietary restrictions? *

- Yes
- No

If yes, please describe. *

Please comment on any additional health information you may want program organizers to be aware of. *

Have you ever requested or received academic accommodation related to a learning disability or physical limitation? *

- Yes
- No

If yes, please describe. *

Additional Acknowledgements

I understand that if my health condition should change before I leave for my faculty-led program, I am responsible for communicating that information to the individual responsible for the faculty-led program at YSU (Amy Cossentino: alcossentino@ysu.edu)

- Yes
- No

By typing my name in this box, I certify that the answers above are true and accurate.*

Please enter the date of completion of this form. *