#### **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. \*

- o Yes
- o 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. \*

- o Yes
- o 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. \*

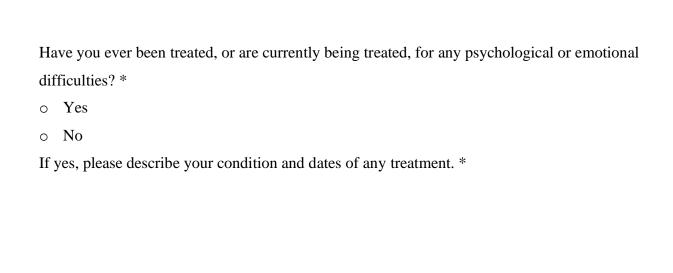
- o Yes
- o No

# Medical history

Are you generally in good physical condition? \*

- o Yes
- o No

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



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

- o Yes
- o 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)? *
o Yes
o 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.*
o Yes
o No

Have you had any major injuries, diseases or ailments over the past five years?*
o Yes
o No
If yes, please describe and list dates.*
Do you have any dietary restrictions? *
o Yes
o No
If yes, please describe. *
Please comment on any additional health information you may want program organizers to be aware of. $\ast$

Have you ever requested or received	dacademic accommod	ation related to a lea	arning disability or
physical limitation? *			

- o Yes
- o 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)

- o Yes
- o 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. \*