

UNIVERSITY OF NOTRE DAME

INSTITUTE FOR SCHOLARSHIP IN THE LIBERAL ARTS (ISLA)

245 O'Shaughnessy Hall
Notre Dame, Indiana 46556
(574) 631-1135

HEALTH QUESTIONNAIRE

Instructions: Bring this entire completed & signed form with you for your appointment at University Health Services. They will complete Section B and return the form to ISLA. Your personal physician may complete and submit the form if he/she has seen you within the past year. The physician must return **all four pages** of the completed form directly to ISLA in a sealed business envelope bearing the office address. Incomplete forms will not be accepted. Students may not personally bring or send this form to the ISLA office.

Section A (Completed by student)

Student's Name: _____

Student's Notre Dame I.D.#: _____

Name/Location of International Travel: _____

Dates of Travel: _____

In order to allow the University to provide appropriate assistance to you during your international travel, it is important that we be aware of any medical or emotional conditions, past or current, that might influence your ability to live, study or travel abroad for an extended period of time. This information will be kept confidential as provided herein by the University and the host institution, if any, for your study abroad program. It will not be used to prevent you from participating in the program unless your treating health care provider deems you unfit to participate, or unless your participation would require the University to fundamentally alter an academic program or take unreasonable steps to accommodate your condition. Disclosure of the requested information is intended to ensure that your needs are being attended to and to create a positive and healthy experience. If you require ongoing medical care, treatment, or medications, you must have your treating health care provider submit a written treatment plan to be carried out while abroad as part of Section B.

1. Have you had any serious illnesses, injuries or medical conditions within the **past five years** for which you have received or are presently receiving professional medical treatment?

No: _____

Yes: _____ If yes, please describe:

2. Within the **past five years**, have you experienced a mental, emotional, or psychological disorder (e.g., eating concerns, depression, substance abuse)?

No: _____

Yes: _____ If yes, please describe, including any treatment received:

3. Do you have any physical or mental condition that may require special facilities or assistance while abroad? (If appropriate, please attach a memo from the Office of Students with Disabilities indicating the condition and your needs.)

No: _____

Yes: _____ If yes, please describe:

4. Do you suffer from any allergies (e.g., food, medicine, insects, etc.)?

No: _____

Yes: _____ If yes, please describe: _____

5. Do you have any dietary restrictions or special dietary needs?

No: _____

Yes: _____ If yes, please describe: _____

6. Are you currently taking any medications?

No: _____

Yes: _____ If yes, please list the medications:

7. Please list any immunizations you have received in the last 90 days:

PERMISSION FOR EMERGENCY TREATMENT: I hereby grant permission for designated representatives of the University and/or the study abroad host institution, if any, to consent on my behalf to the provision of emergency medical care, including but not limited to the examination, diagnosis and treatment of any emergency condition or injury that I may sustain or experience during the study abroad program. This consent shall include, but not be limited to, emergency blood transfusions, surgical procedures, the administration of anesthesia and other medical tests and procedures recommended by medical authorities. All such treatment shall be at my expense, and I agree to reimburse the University or its representatives for any expenses that they or any of them might incur

on account of my condition or treatment. This consent shall not give rise to, and is not intended to give rise to a legal duty owed by the University to me, and I hereby release and discharge the University and its employees, agents, officers, trustees and representatives from any and all claims, actions, causes of action, expenses (including any health insurance deductibles), damages and judgments arising out of or related to the University granting or failing to grant, seek or adequately supervise medical care on my behalf or arising out of or related to the University's own negligence.

PERMISSION FOR RELEASE OF MEDICAL OR MENTAL HEALTH INFORMATION: I hereby agree to sign any authorization for release of medical or mental health records/information provided by a treating health care provider that is related to my participation in a study abroad program or my well-being while studying abroad.

HEALTH INSURANCE DISCLOSURE: I acknowledge that the University shall directly enroll me in a third party international travel insurance plan through HTH Worldwide that shall provide me with a certain degree of medical coverage during international travel in the course of the study abroad program, and I understand that such coverage is a precautionary requirement and that the University makes no representations or warranties about the adequacy of such insurance for my personal situation. For the purpose of enrolling me in the international travel insurance plan through HTH Worldwide, I grant the University permission to disclose to HTH Worldwide any or all of the following information about me: full name; email address; mailing address; date of birth; and any other information in the University's possession about me that HTH Worldwide requires for my enrollment in its international travel insurance plan. I agree that the permissions and consents I am giving in this paragraph shall not be limited by, affected by, or otherwise subject to any direction or notice I have given or will give in the future to the University pursuant to the Family Educational Rights and Privacy Act ("FERPA") restricting its ability to designate information about myself as directory information under FERPA or restricting its ability to disclose directory information about myself as such information is designated by the University under FERPA.

STUDENT CERTIFICATION: I certify that all responses made on this form are true, complete and accurate, and I agree to notify ISLA of any relevant changes, including a change in the state of my health or mental health that might impact my participation in the study abroad opportunity, at any time prior to the end of the program. I understand that the completion and submission of this entire form is required in order for me to participate in the study abroad opportunity. I further understand that providing false information (or failing to provide truthful responsive information) on this form may result in University disciplinary action against me, including but not limited to revocation or early termination of my participation in the study abroad program at any time.

Student's Signature: _____

Student's Name Printed: _____

Date: _____

Section B (To be completed by health care provider who has seen student within the past year)

HEALTH CARE PROVIDER:

The student listed below has been selected to participate in a study abroad program. Depending upon the program, students spend from a few days to a full year studying, living and traveling abroad. Living and studying in a foreign environment often creates unexpected emotional and physical stress which can exacerbate otherwise mild conditions. It is important that all participants be able to adjust to dramatic changes in their living environment, climate, diet, living conditions and studying conditions that may disrupt accustomed patterns of behavior. Your complete and candid evaluation of the student's health is, therefore, extremely important to the Institute of Scholarship in the Liberal Arts in anticipating and working with the student to appropriately address any problems that might arise during the student's international travel.

Patient Name: _____ Date of Birth: _____

Based on my assessment of _____, this student is:
(Patient Name)

- Able to participate in the study abroad program without restrictions.
- Able to participate in the study abroad program with the following restrictions or recommendations (please attach a written treatment plan to be carried out abroad if necessary):

- Not recommended for participation in a study abroad program for the following reason(s):

Specialist or Treating Provider:

(Signature)

(Print Name)

(Date)

Office Address: _____

Area of Specialization: _____ Date of Exam: _____

- PLEASE MAIL:**
- 1) The complete, signed *Health Questionnaire (4 pages total)* and
 - 2) Blank copy of office letterhead or business card in a business envelope bearing your office address to:

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ISLA will not accept submission of this page without the accompanying Section A.

Questions? Call 574-631-1135