Appalachian
STATE UNIVERSITY
Office of International Education and Development
263 Locust Street
PSU, Suite 321
ASU Box 32083
Boone, NC 28608-2083
Tel: (828) 262-2046
Fax: (828) 262-4037
Web: www.international.appstate.edu

Student Name:

Health Self-Disclosure Form

This form is voluntary and is not required to be completed to participate in any study abroad program. It is, however, highly encouraged to provide OIED, Student Health Services, the Appalachian Counselling Center, the Office of Disability Services, your program leaders and others the ability to adequately address any needs you may have during your program.

Please answer the questions contained in this form as honestly and completely as possible. It is very important that all sections are completed fully and accurately, as this will assist health care providers should you require medical or counseling services during your study abroad program. The information provided will be treated confidentially. However, you agree that this information may be used by OIED personnel to help you plan for your experience abroad. OIED offers a system-wide HTH Medical Plan that enables you to: (1) check what medical facilities are available in the host country; (2) make medical appointments on-site prior to departure if medical care will be needed during the program; and (3) send medical records to a medical care provider overseas prior to departure, if needed.

By accepting below I hereby give my permission for the OIED personnel to release my health disclosure form to Student Health Center's Travel Clinic, the Appalachian State University Counseling Center, the Office of Disability Services and, where applicable, to my Program Leader. I understand that this information will be shared only when necessary for my own or others' health and safety or to be sure arrangements can be made to meet my needs.

In the event of illness, injury, or other medical emergency, I hereby grant Appalachian State University or any of its representatives, full authority to take any action deemed necessary to protect my mental or physical health and safety, at my expense, and to secure necessary treatment, including placing me under the care of a doctor or in a hospital or any place for medical examination or treatment, the administration of an anesthetic and surgery, and/or the administration of medication as may be prescribed by a doctor or if necessary for my safety or health . I agree that I may be returned to the United States at my expense. I agree that if Appalachian State University makes any payments on my behalf, I will reimburse the University regardless of whether I deem the treatment or services received to be medically necessary. I hereby assume all responsibility for all medical expenses that I may incur while abroad including the costs of my evacuation or return for medical or other reasons. I authorize Appalachian State University to contact my Parents/Legal Guardian/Spouse about my physical or mental health while I am abroad if the University deems it advisable to do so.

I understand and agree that Appalachian State University is not obligated to secure or pay for medical treatment on my behalf and cannot guarantee the quality of any such treatment. I hereby release Appalachian State University, the University of North Carolina and their respective trustees, officers, employees and agents from any and all liability, claims and causes of actions that might arise as a result of the exercise of their authority under this Agreement.

I certify that all responses made on this Health Disclosure Form are true and accurate, and that I will notify the University of any relevant changes in my health that occur prior to or during the term of the Program. I understand that this form is for information purposes only and in no way obligates the University or Program leader to take any responsibility for my health.

I have read and understand this document and agree that it will legally bind me and my estate, and I sign it voluntarily.

____

Student Signature & Date

____

Student Printed Name

If the participant is under eighteen (18) years of age, this document must be signed by both the student above and on behalf of the participant by his or her parent or legal guardian. I have read and understand this document, I understand and agree that it will legally bind me and my estate, and I sign it voluntarily.

____

Signature & Date

____

Printed Name

____

Relationship to Participant (Parent or Guardian)

Student Name:

Program/Country Term/Year

1. Please list all current prescriptions and over the counter medications you take regularly as well as your plan for continuing them abroad. Some drugs available by prescription or over the counter in the US are illegal in other countries. Advanced preparation is important in having a successful education abroad experience. **Prescriptions / Medications (including over the counter Medications):***(example: Adderall, Levora, Benadryl, Sudafed, Metformin, ProAir, etc.)*

   Reason/Condition: *(example: ADHD, Diabetes, Epilepsy, Seasonal Allergies, Birth Control, Asthma, etc.)*

   Plan: *(example: this medication is legal in my host country and I will bring a 3 month prescription with me)*

2. Do you have any allergies (to medications, foods, insect bites, etc.)? If yes please list the allergy below, the severity of the allergy, and your plan for coping with any allergens. This question is important as exposure to allergens may be higher than what you experience locally.

3. Do you have any dietary restrictions (e.g. vegetarian, kosher, halal, restricted diet, etc.)? If yes please describe the plan you have in place for your time abroad. Your host country's diet may differ significantly from what you are used to so advanced reseach is important.

Student Name:

4. Are you currently being treated for or have ever been treated in the last 5 years for any mental health conditions (e.g. addiction, depression, anxiety, eating disorder, condition due to loss or grief, etc.)? If yes please describe below and provide your plan for managing the condition(s) while abroad if applicable.

5. Are you currently being treated for or have ever been treated in the last 5 years for any physical health condition, injury, or diseases (e.g. asthma, chronic conditions, cancer, cardiac conditions, epilepsy, migraines, etc.)? If yes please describe below and if applicable provide your plan for managing the condition(s) while abroad.

6. Do you believe you have a health condition or disability (e.g. learning disability, attention deficit disorder, diabetes, epilepsy, mobility restriction, visual or hearing impairment, mental health, or other) that may require reasonable accommodations to fully participate in a study abroad program? Yes or No. *If Yes please contact the Office of Disability Services https://ods.appstate.edu as soon as possible —to determine eligibility for a reasonable accommodation. Accommodations will vary by program location so contacting ODS early on is important in having a successful education abroad experience.*

7. Is there any additional information that would be helpful for the program to be aware of during your study abroad experience? (If yes please explain below)

Please feel free to consult your private medical practitioner, Student Health Services, Counseling and Psychological Services, Office of Disability Services, and OIED if you have any questions about how to answer these questions. Please also consult the Health and Safety section of our website for additional resources: ***https://international.appstate.edu/education-abroad/health-and-safety***