GOUCHER COLLEGE OFFICE OF GLOBAL EDUCATION
STUDENT HEALTH HISTORY FORM
PART A

All students must submit a health information form signed by a medical provider, regardless of whether you have a medical condition, in order to participate in a study abroad program. **FAILURE TO SUBMIT THE FORM BY THE DEADLINE MAY RESULT IN YOUR WITHDRAWAL FROM THE PROGRAM.** Information from the form will be sent to the director of your program so that they may assist you properly in case of an emergency.

PLEASE NOTE THAT YOU MUST INFORM THE OFFICE OF GLOBAL EDUCATION OF ANY RECENT MEDICAL OR SPECIAL NEEDS OR CHANGES IN HEALTH THAT OCCUR BEFORE THE START OF THE PROGRAM.

(Print) Legal Last Name:_____ **First** _____ **Middle** _____

Chosen or Preferred Name _____

Sex Assigned at Birth: ☐M ☐F ☐Intersex **Date of Birth:** Month_____ Day_____ Year_____

Gender identity (check as many as are appropriate):

- ☐ Female
- ☐ Male
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Genderqueer/Non-binary
- ☐ Other (Please specify)

Goucher Student I.D. # _____

Name/location of study abroad program _____

Person(s) to notify in case of emergency Phone number(s)

_____ _____
(Name) (Relation) Home Work Cell

Health professional name _____ Phone _____

PERSONAL HEALTH HISTORY

DATE COMPLETED: _____

_

(Print) **Legal Last Name**_____**First** _____**Middle** _____

HAVE YOU EVER HAD THE FOLLOWING CONDITIONS?	DATE	DO YOU CURRENTLY HAVE THE FOLLOWING CONDITIONS?	CHECK All THAT APPLY*
ADHD		ADHD	☐
Asthma/Hay Fever		Asthma/Hay Fever	☐
Back/joint problems		Back/joint problems	☐
Exercise-induced asthma		Exercise-induced asthma	☐
Cancer/tumors		Cancer/tumors	☐
Alcohol/drug dependency		Alcohol/drug dependency	☐
Convulsive Disorders		Convulsive disorders	☐
Depression/anxiety/ bi-polar/panic attacks		Depression/anxiety/ bi-polar/panic attacks	☐
Diabetes		Diabetes	☐
Eating disorders		Eating disorders	☐
Heart disease		Heart disease	☐
Hepatitis		Hepatitis	☐
Hypoglycemia		Hypoglycemia	☐
Kidney Disease		Kidney Disease	☐
Migraine headaches		Migraine headaches	☐
Mononucleosis		Mononucleosis	☐
Other psychiatric disorder		Other psychiatric disorder	☐
Stomach/intestinal disorders (e.g., Crohn's)		Stomach/intestinal disorders	☐
Thyroid disease		Thyroid disease	☐
Tuberculosis		Tuberculosis	☐
Other:		Other:	☐

*** Please provide additional information about checked items on an attached sheet.**

STUDENT SELF-ASSESSMENT

(Print) **Student Legal Last Name**_____**First**_____**Middle**_____

Respond honestly to the questions below. These questions are designed to help ensure you have a plan in place should any issues arise with the conditions you listed on your Health History Form. If the questions does not apply to you, check the box indicating so.

1. Have you had any illnesses, injuries, or medical conditions within the past year for which you have received or are presently receiving professional medical treatment?
   No: ☐ Yes: ☐

   If yes, please describe below. You must provide the name and phone number for your healthcare professional on page 5. This healthcare professional must also complete a Part B for condition you are being treated for or receiving prescribed medications.

   _____

   _____

   _____

2. Have you had any mental, emotional or psychological conditions, eating disorders, within the past year for which you have received or are presently receiving treatment from a mental health professional or substance abuse counselor?
   No: ☐ Yes: ☐

   If yes, please describe below. You must provide the name and phone number for your healthcare professional. This health care professional must also complete a Part B for the condition you are being treated for or receiving prescribed medications.

   _____

   _____

3. If you have a mental health or other chronic medical condition that is exacerbated by stress, in a scenario where you are very stressed (i.e. dealing with school work, culture shock, language barriers, etc.) while studying abroad, how would you cope? What is your strategy? Who is your support team that will respond if you need help? ☐ **Does not apply to me**

   _____

   _____

   _____

4. a. List any medications you are currently taking. Include dosage amounts. ☐ **Does not apply to me**

   _____

   _____

   _____

b. What is your plan for continuing the use of your prescription medications? Consider the following: if your medication is legal and/or available in your host country, and that medications should not be sent through the mail as they can be confiscated and/or delayed. ☐ **Does not apply to me**

5. Do you have any allergies (food, medicine, insects, etc.)?
   No: ☐ Yes: ☐

   If yes, please describe:

6. Do you have any dietary restrictions or special dietary needs?
   No: ☐ Yes: ☐

   If yes, please describe:

7. If you have mobility issues, how will you manage a different system of public safety? For example, in many countries, pedestrians do not have the right of way even when crossing the cross walk. Or, the roads and sidewalks may be uneven or made of cobblestone causing a potential risk for anyone with mobility issues. How would you approach this safety concern? ☐ **Does not apply to me**

   If you are unable to participate in some or all program activities (i.e. hiking trips, tours, field research, etc.) because your condition prevents you from doing so, what would you do?
   ☐ **Does not apply to me**

8. If you are currently recovered from or have dealt with substance abuse or an eating disorder, what strategies will you put into place to maintain your recovery? Who is your support team that will respond if you need help? ☐ **Does not apply to me**

9. What is your plan if your health condition becomes an acute emergency overseas?

List ALL health professionals (doctor, nurse practitioner, psychologist, counselor, etc.) you have seen during the past year on this form and include contact information.

1. **Name:** _____

   Specialty: _____

   Phone: _____

   Email/website: _____

   Conditions treated: _____

2. **Name:** _____

   Specialty: _____

   Phone: _____

   Email/website: _____

   Conditions treated: _____

3. **Name:** _____

   Specialty: _____

   Phone: _____

   Email/website: _____

   Conditions treated: _____

4. **Name:** _____

   Specialty: _____

   Phone: _____

   Email/website: _____

   Conditions treated: _____

PERMISSION TO SHARE INFORMATION: I hereby give the Office of Global Education (or a designee) and other representatives of the college permission to communicate with one another and/or with my parents, immediate family members, emergency contact person(s), doctor(s) and /or health care professionals regarding my study abroad experience, as necessary for college officials to perform their job duties. This may include but is not limited to the release of information from this health care form and my other educational records about my health and safety, student conduct or disciplinary matters, academic issues, student account information and/or any other relevant conduct or circumstance before or during the Program experience.

Student Signature: _____

_____

CERTIFICATION: I certify that:

1. I have personally completed this form. The information contained in this form is complete and I have not withheld any information about my physical or mental health. If any aspect of my health profile changes between submitting this form and my departure for an off-campus program, I will notify the Office of Global Education of these changes immediately , in writing . I understand that my failure to disclose any medical or mental health information may jeopardize my ability to receive appropriate medical care in the event of an emergency abroad. I further understand that, in the event of an emergency abroad, the college reserves the right to notify my parent(s) or guardian.

Check EITHER (a) or (b) below:

2. (a) ☐ I checked no or "not applicable" to every question on page 2 and certify that I am in good physical and mental health and I do not suffer from any mental or physical problem or condition that limits my activities or would prevent me from successfully taking part in the study abroad program in

_____

(b) ☐ I have accurately completed Page 2 and will provide medical records from clinicians who have treated me for any condition indicated on questions 1, 2, and 8 of that page, documenting that I am able to successfully take part in the study abroad program in

_____

Student Signature:

Student Name: _____

Date: _____

GOUCHER COLLEGE OFFICE OF GLOBAL EDUCATION

STUDENT HEALTH HISTORY FORM

PART B

PROVIDER ASSESSMENT

MUST BE COMPLETED BY A LICENSED MEDICAL OR MENTAL HEALTH PROVIDER WHO HAS SEEN THE STUDENT WITHIN THE PAST YEAR.

IF MENTAL OR PHYSICAL CONDITION(S) ARE LISTED IN PART A (QUESTIONS 1,2, AND/OR 8), THE PROVIDER(S) WHO HAVE TREATED THE STUDENT FOR THESE CONDITIONS MUST FILL OUT THIS FORM.

TO: _____

TREATING PROVIDER'S NAME (PRINT)

FROM: _____

STUDENT NAME (PRINT AND SIGN)

I am requesting that you complete this PROVIDER ASSESSMENT form in order to assess my potential needs in my study abroad program. I will share this information with Goucher College and I give you permission to discuss my situation with the Goucher College Office of Global Education and other staff members of the college working to assess my ability to study abroad.

STUDENTS: SUBMIT MULTIPLE COPIES OF THIS FORM AS NEEDED.

Note to the provider: *Please attach a blank copy of your office letterhead or a business card and return with the Health Questionnaire to Office of Global Education, Goucher College, 1021 Dulaney Valley Road, Baltimore, MD 21204.*

Telephone: 410-337-6455 Fax: 410-337-6443

The above-named student has been selected to participate in an international study abroad program. 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, and studying conditions that may disrupt their usual patterns of behavior. Your complete and candid evaluation of the student's physical and mental health is, therefore, extremely important to the the Office of Global Education in working with the student to appropriately address any problems that might arise during the student 's international study abroad experience.

Please complete the form on the next page:

(Print) **Student Legal Last Name**_____ **First**_____ **Middle**_____

ASSESSMENT (TO BE COMPLETED BY PROVIDER)

1. Diagnosis and description of student's health condition or disability:

   _____

2. Date of onset: _____

3. Prescribed medication and dosage [**NOTE**: students who are currently being prescribed medication must submit an assessment (Another Part B) from the prescribing provider]

   _____

4. If on medication, should the student continue on the medication throughout the time abroad?

   _____

5. What limitations are there, if any, on this student's participation in an extremely rigorous (emotionally and physically) overseas program?

   _____

6. What accommodations are needed to assist the student in fully participating in the program?

   _____

7. What is the prescribed plan in the event that this condition becomes an acute emergency overseas?

   _____

8. **Based on the information provided by the student on this Student Health History Form, on your personal review of the student's health history, on your recent physical examination of the student, on his/her medical records on file in your office, and on Part A of this form, please state whether in your professional opinion:**

   ☐ There are no known contraindications to this student's participation in the program at this time.

   ☐ There are medical or mental health contraindications to this student's participation in the program at this time (please describe the contraindications and how they impact the student's participation in the program; submit additional sheets if necessary):

   _____

   _____

   _____ _____

   Licensed Provider's Signature **Licensed Provider's Name** (printed)

   Date:_____