# Lasallian International Programs Consortium
# Health Information Form

The purpose of this form is to help study abroad administrators be of maximum assistance to you should the need arise during your study abroad experience. The information provided will remain confidential and will be shared with appropriate professionals only if pertinent to your well being.

**Name** _____ **Home University**_____

Birthdate ___/____/____ Gender M F Study Abroad Program _____

Physician's Name _____Telephone _____

Address _____ Fax _____

Insurance Plan #1 _____ Policy # _____

Insurance Plan #2 _____ Policy # _____

Yes___No___ 1. Do you have any medical conditions (including allergies) or physical disabilities? (If yes, please explain.)

Yes___No___ 2. Have you ever been treated for any psychological or emotional problems, including alcohol or chemical abuse, at any time over the past five years? (If yes, please explain)

Yes___No___ 3. Have you had any major injuries, diseases, or ailments in the past five years? (If yes, please explain)

Yes___No___ 4. Are you currently taking any medications? (If yes, please list as directed below.)

Prescription Name, Strength & Dosage
_____

Prescription Name, Strength & Dosage
_____

Prescription Name, Strength & Dosage
_____

Yes___No___ 5. Do you have any dietary restrictions or considerations? (If yes, please explain.)

Yes___No___ 6. Is there any medical information not already included on this form that you feel a study abroad administrator should know in case of emergency? (If yes, please explain.)

*In the event that my Emergency Contacts cannot be contacted in case of emergency, I, the undersigned, hereby give permission for the appropriate representative from the Lasallian International Programs Consortium to authorize immediate medical treatment. I certify that all responses made on this Health Information Form are true and accurate, and I will notify the appropriate study abroad program administrator hereafter of any relevant changes in my health that occur prior to the program.*

**Signature of Participant** _____ **Date** _____