

## Health Information

Your Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Student ID# \_\_\_\_\_ Gender \_\_\_\_\_ Program \_\_\_\_\_ Term \_\_\_\_\_

*The purpose of this form is to help the Program Director to be of maximum assistance to you should the need arise during your study abroad program. Mild physical or psychological disorders can become serious under the stresses of life while studying abroad. It is important that this office be made aware of any medical or emotional problems, past or current, which might affect you in a foreign study context. The information provided will remain confidential and will be shared with program staff, faculty, or appropriate professionals only if pertinent to your own well-being. The University of Montana and the program that you are participating in may not be able to accommodate all individual needs or circumstances. This information does not affect your admission into the program.*

### MEDICAL HISTORY

Yes \_\_\_\_ No \_\_\_\_ 1. Are you generally in good physical condition? (If no, please explain.)

Yes \_\_\_\_ No \_\_\_\_ 2. Have you ever been treated or are you currently being treated for any psychological or emotional problems? (If yes, please explain.)

Yes \_\_\_\_ No \_\_\_\_ 3. Do you have any allergies? (If yes, please explain.)

Yes \_\_\_\_ No \_\_\_\_ 4. Are you taking any medications on a regular basis? (If yes, please explain.)

Yes \_\_\_\_ No \_\_\_\_ 5. Have you had any major injuries, diseases, or ailments in the past five years? (If yes, please explain.)

Yes \_\_\_\_ No \_\_\_\_ 6. Are you a vegetarian or are you on a restricted diet? (If yes, please explain.)

Yes \_\_\_\_ No \_\_\_\_ 7. Is there any additional information (concerning medical conditions or physical disabilities) that would be helpful for this office and the program to be aware of during your study abroad experience? (If yes, please explain.)

*I certify that all responses made on this Health Information form are true and accurate, and I will notify the Program Director hereafter of any relevant changes in my health that occur prior to the start of the program.*

Signature of Participant \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_