

STUDY ABROAD

Health Information Form

Congratulations on your acceptance to an Ohio State study abroad program. It is important that we be aware of any past or current medical issues, including mental health conditions, which might affect your participation. This information will be kept confidential in accordance with applicable law and handled with the highest level of discretion to protect student privacy. Disclosure of such information may be made to appropriate individuals (including program staff and resident directors) and to provide you with assistance should the need arise during your study abroad experience. Health tests, certifications, or other actions may also be required prior to departure in certain circumstances.

The Office of International Affairs is committed to enabling participation in its study abroad programs for all qualified individuals with disabilities. We work closely the Office for Disability Services to provide access. If you have questions about accessibility, need assistance in order to participate, or wish to discuss accommodations for a disability, please contact your OIA Study Abroad Coordinator and/or the Office for Disability Services. Accommodations may require extensive planning and communications with foreign contacts, so adequate lead time is critical. Contact should accordingly be initiated as soon as possible.

Completed by Participant	
Last Name:	First Name: M.I.: Birth Date: ____/____/____ Student ID #:
Program:	Semester(s)/Year(s):
Medical History	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been or are you currently being treated for a physical health condition? (If yes, please explain and list your doctor's name and contact information for any current physical health condition(s).)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been or are you currently being treated for a mental health condition (psychological or emotional)? (If yes, please explain and list your doctor's name and contact information for any current mental health condition(s).)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any allergies? (If yes, please explain.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking any medications? (If yes, please explain.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any major injuries, diseases, or ailments in the past five years? (If yes, please explain.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a vegetarian or are you on a restricted diet? (If yes, please explain.)
Please list any additional information that would be helpful for the program to be aware of during your study abroad experience.	

I certify that all responses made on this Health Information form are true and accurate to the best of my knowledge. I will promptly notify the Office of International Affairs hereafter of any relevant changes in my health that occur prior to the start of the program. I understand and acknowledge that failure to disclose any relevant health issues may result in dismissal from the program and/or other action as appropriate.

Type Participant Name: _____ Date: _____