UNIVERSITY AT BUFFALO
Study Abroad Programs

Student Health Information 2011 – 2012

Please type or print in ink.

First Name ________ Last Name ________ Study Abroad Program ________

To the Student: Please complete this form with as much information as possible and review it with your physician(s). The information provided by you and your physician(s) will remain confidential.

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

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

3. Do you have any other on-going emotional or physical conditions (including eating disorders) that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? (If yes, please explain.) ☐ Yes ☐ No

4. Do you have any allergies, reactions to medications and/or dietary restrictions? (If yes, please explain.) ☐ Yes ☐ No

5. Are you currently taking any medications? (If yes, please list medication name and reason for taking it.) ☐ Yes ☐ No

6. Have you had any major injuries, diseases, or ailments in the last five years? (If yes, please explain.) ☐ Yes ☐ No

7. (***Disclosure of disabilities is optional)***. Do you have a disability for which you are seeking accommodations? If yes, please provide a description of desired accommodations. *Please be aware that the Americans with Disabilities Act (ADA) does not apply outside the borders of the U.S. However, the University at Buffalo will assist you, to the extent possible, to obtain the accommodations you may want. We may not be able to obtain the accommodations necessary to enable you to participate in all aspects of the overseas program.* ☐ Yes ☐ No

8. Person to notify in case of emergency, illness or accident:

Name: ______________________________________ Relationship to student: ______________________________

Street/Apt #: __________________________________ Daytime Telephone #: (_____)__________________________

City, State, ZIP: _______________________________ Evening Telephone #: (_____)__________________________

E-mail Address: _______________________________ Cell Telephone #: (_____)___________________________

I grant the State University of New York, its employees, agents and overseas partners permission to communicate concerning my health condition with program representatives, my family, insurance company representatives and with any physician, psychologist or counselor who treated me during the past five years or is now treating me. In situations where I am unable to give oral or written consent, I further grant permission for hospitalization and treatment recommended and carried out under the supervision of a qualified physician, including administering anesthetics and performing necessary surgery at my own expense. I further appoint the representative of SUNY in the host country for the program to act on my behalf in authorizing necessary medical, dental or surgical care, hospitalization or medical evacuation for me should this be required.

I certify that all responses made on this form are true and accurate, and that **I will notify the University at Buffalo Study Abroad Programs hereafter of any relevant changes in my health that occur prior to the start of the program.** I also certify that I have been advised to consult my physician(s) for any pre-existing physical or emotional conditions.

________________________________ ________________
Student's Signature *Date*

________________________________ ________________
Parent/Guardian's Signature (required if student is under 18 years of age) *Date*