UNIVERSITY OF NOTRE DAME
NDI- INTERNATIONAL STUDIES

105 Main Building
Notre Dame, Indiana 46556
(574) 631-5882

(***Due April 15th for Summer, Fall and AY Participants; November 1st for Spring Participants)***

HEALTH QUESTIONNAIRE

Instructions: Interactive fields in Section A are to be filled in online by the student, providing thorough and complete information. **Print the form; University Health Services (UHS) will not print the form for you.** Sign where indicated. Bring the entire completed, signed form to your appointment at UHS. UHS will complete Section B and return the form to the International Studies office. The student's personal physician may complete and submit the form if he/she has seen the student within the past year. **The physician must return all four pages** of the completed form directly to our office in a sealed business envelope bearing the office address. Incomplete forms will not be accepted. **Students may not bring or send the form to the International Studies office.**

Section A (to be completed by student)

Student's Name:_____

Student's Notre Dame I.D.#: _____

Name/location of study abroad program: _____

Length of Program (check one):

Academic Year_____ Fall Semester Only_____ Spring Semester Only_____ Summer Only _____

Congratulations on your recent acceptance for participation in a University study abroad program. In order to allow the University to provide appropriate assistance to you during your study abroad experience, it is important that we be aware of any medical or emotional conditions, past or current, that might influence your ability to live, study or travel abroad for an extended period of time. This information will be kept confidential as provided herein by the University and the host institution, if any, for your study abroad program. It will not be used to prevent you from participating in the program unless your treating health care provider deems you unfit to participate, or unless your participation would require the University to fundamentally alter an academic program or take unreasonable steps to accommodate your condition. Disclosure of the requested information is intended to ensure that your needs are being attended to and to create a positive and healthy experience. If you require ongoing medical care, treatment, or medications, you must have your treating health care provider submit a written treatment plan to be carried out while abroad as part of Section B.

1. Have you had any serious illnesses, injuries or medical conditions within the **past five years** for which you have received or are presently receiving professional medical treatment?

No: _____
Yes: _____

If yes, please describe:_____
_____
_____

2. Within the **past five years,** have you experienced a mental, emotional, or psychological disorder (e.g., eating concerns, depression, substance abuse)?

No: _____
Yes: _____

If yes, please describe, including any treatment received:
_____
_____
_____

3. Do you have any physical or mental condition that may require special facilities or assistance while abroad? (If appropriate, please attach a memo from the Office of Students with Disabilities indicating the condition and your needs.)

No: _____
Yes: _____

If yes, please describe:
_____
_____
_____

4. Do you suffer from any allergies (e.g., food, medicine, insects, etc.)?

No: _____
Yes: _____

If yes, please describe: _____

5. Do you have any dietary restrictions or special dietary needs?

No: _____
Yes: _____

If yes, please describe: _____

6. Are you currently taking any medications?

No: _____
Yes: _____

If yes, please list the medications:

_____

_____

7. Please list any immunizations received in the last 90 days:

_____

_____

PERMISSION FOR EMERGENCY TREATMENT: I hereby grant permission for designated representatives of the University and/or the study abroad host institution, if any, to consent on my behalf to the provision of emergency medical care, including but not limited to the examination, diagnosis and treatment of any emergency condition or injury that I may sustain or experience during the study abroad program. This consent shall include but not be limited to emergency blood transfusions, surgical procedures, the administration of anesthesia and other medical tests and procedures recommended by medical authorities. All such treatment shall be at my expense, and I agree to reimburse the University or its representatives for any expenses that they or any of them might incur on account of my condition or treatment. This consent shall not give rise to, and is not intended to give rise to a legal duty owed by the University to me, and I hereby release and discharge the University and its employees, agents, officers, trustees and representatives from any and all claims, actions, causes of action, expenses (including any health insurance deductibles), damages and judgments arising out of or related to the University granting or failing to grant, seek or adequately supervise medical care on my behalf.

PERMISSION FOR RELEASE OF MEDICAL OR MENTAL HEALTH INFORMATION: I hereby agree to sign any authorization for release of medical or mental health records/information provided by a treating health care provider that is related to my participation in a study abroad program or my well being while studying abroad.

STUDENT CERTIFICATION: I certify that all responses made on this form are true, complete and accurate, and I agree to notify the Director of NDI-International Studies at the University (or his/her designee) of any relevant changes, including a change in the state of my health or mental health that might impact my participation in the study abroad program, at any time prior to the end of the program. I understand that the completion and submission of this entire form is required in order for me to participate in the study abroad program. I further understand that providing false information (or failing to provide truthful responsive information) on this form may result in University disciplinary action against me, including but not limited to revocation or early termination of my participation in the study abroad program at any time.

Student's Signature: _____

Student's Name Printed: _____

Dated:_____

Section B (to be completed by a health care provider who has seen student within the past year)

A NOTE TO THE HEALTH CARE PROVIDER: ***The complete Health Questionnaire (4 pages, total) is to be returned by mail to the NDI-International Studies office in a business envelope bearing your office address. NDI-International Studies will not accept submission of this page 4 without the accompanying Section A. Please attach a blank copy of your office letterhead or a business card.***

The above-named student has been selected to participate in a study abroad program. Depending upon the program, students spend from a semester to a full year studying, living and traveling abroad. 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, living conditions and studying conditions that may disrupt accustomed patterns of behavior. Your complete and candid evaluation of the student's health is, therefore, extremely important to the International Studies office in anticipating and working with the student to appropriately address any problems that might arise during the student's study abroad program.

Patient Name: _____ Date of Birth: _____

To be completed by specialist or treating provider:

Based on my assessment of _____, this student is:
(patient name)

☐ Able to participate in the study abroad program without restrictions

☐ Able to participate in the study abroad program with the following restrictions or recommendations (please attach a written treatment plan to be carried out abroad if necessary):
_____
_____

☐ Not recommended for participation in Study Abroad Program

Reason(s):
_____
_____
_____

Name of specialist or treating provider:

_____ _____ _____
(Signature) *(Print Name)* *(Date)*

Office Address: _____
_____
_____

Area of specialization:_____ Date of exam: _____