University of Missouri-St. Louis
Center for International Studies
Study Abroad Office

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HEALTH INFORMATION FOR STUDY ABROAD

Accurate completion of this form enables the Study Abroad Office to obtain information regarding facilities available for study abroad students who have specific health concerns. The form may be forwarded to either the faculty advisor or host university's international office to help make arrangements that might be necessary or to be used in case of an emergency. The form is a confidential document and any and all information you provide will be disclosed only as necessary to provide for your health and well-being. The disclosure of medical information will not affect your admission status.

Please return the form to the Study Abroad Office, 261 MSC

Name:_____ Student #:_____ Term(s) Abroad:_____

1. List any serious or chronic illnesses, surgery or injuries that may affect your health while abroad.

2. List any allergies that you have including hay fever, asthma or food allergies.

3. Do you have a disability or any other condition that might require special accommodation? If yes, please explain the type(s) of services that you might require.

4. Are you presently seeing a counselor or other medical professional for emotional, psychological, or addiction problems that will require on-going treatment overseas? If yes, please list specifically the type of service or professional that is needed.

5. Will participation in full-time academics or other program elements be limited in any way because of health issues or special needs requirements? If so, please explain.

6. List below any prescription medications that you take including the dosage and frequency of medication. Please note that in some countries it is not possible to fill prescriptions written in the U.S. or to receive medications through the mail.

7. Please note here any other medical concerns you have about study abroad.

I understand that this information will be released to the appropriate overseas contact person or trip leader who is granted permission to use it when, in his or her best judgment, health conditions so warrant.

Signature:_____ Date:_____