STATE UNIVERSITY OF NEW YORK — STUDENT HEALTH INFORMATION
Overseas Academic Programs

Please type or print.

Name:____
Last First Middle

Program:____
Location Abroad Administering Campus

To the Student: Complete this form and review it with your physician during your physical examination. The information provided by you and your physician(s) will remain confidential.

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

2. Have you ever been, or are you currently being treated for any psychological or emotional problems? (If yes, have your physician or counselor attach a note of explanation) ☐ 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, list and indicate recommended treatment) ☐ Yes ☐ No

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

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

6. Have you had any major injuries, diseases, or ailments in the last five years? (If yes, 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 Administering Campus 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 Administering Campus hereafter of any relevant changes in my health that occur prior to the start of the program.**

____
Student's Signature Date

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