



VIRGINIA STATE UNIVERSITY STUDY ABROAD

HEALTH REPORT AND RELEASE

Please complete this form and submit to the
Office for International Education at least 30 days prior to departure.

Dr. George H. Bennett Office for International Education
Room 203 Foster Hall P.O. Box 9086
Virginia State University
1 Hayden Street
Petersburg, VA 23806

Name _____ Program Name _____

Traveling and living abroad presents physical and psychological challenges. Even mild problems may be exacerbated by the stress associated with adjusting to a new cultural environment. If you are not in good physical and emotional health, you should consider carefully your plan to go abroad at this time. If you have any questions about your situation, contact the Office for International Education at (804)524-5986 or Bennettoie@vsu.edu or (for short-term study abroad programs) the faculty member sponsoring your program.

HEALTH DISCLOSURE AND RELEASE

Please answer the questions contained in this form as honestly and completely as possible. FULL DISCLOSURE IS REQUIRED before you will be permitted to participate in any Virginia State University program. It is very important that all sections are completed fully and accurately, as this will assist health care providers should you require medical or counseling services during your term abroad. The information provided will be treated confidentially. In signing this form, you agree to make this information available to the Office for International Education and your faculty program director to make them aware of any special medical needs that you may have or medical issues that may affect your participation in the program.

I, _____ (print name) hereby give my permission for the Director of the Student Health Center and the Counseling Center at Virginia State University to release any Virginia State University health records to the Director of the Office for International Education and to my faculty program leader. I understand that this information will only be shared when necessary for my own health and safety or to be sure arrangements can be made to meet my needs.

Participant's Signature

Date

INSURANCE INFORMATION

All students and faculty participating in a Virginia State University study abroad program must have adequate health insurance to cover them while abroad. Many general policies do cover hospitalization while abroad, but most do not cover medical evacuation and repatriation of remains from abroad. Please provide details about your primary insurance information as requested below.

Primary Insurance Carrier and Policy Number: _____

Name of Policy Holder _____

Relationship of Policyholder to Participant _____

MEDICAL HISTORY

Indicate Gender: Male Female Yes No

1. Do you have physical limitations?
2. Have you ever been treated for an emotional disorder?
3. Are you currently being treated for any psychological/emotional conditions?
4. Are you currently taking any prescription medications?
5. Do you anticipate needing any health care or counseling while abroad?
6. Are you a diabetic?
7. Do you have any dietary restrictions?
8. Do you have epilepsy or other seizure disorders?
9. Do you have asthma?
10. Do you have allergies to food, medicines, plants or animals?
11. Do you have cardiac or circulatory problems?
12. Do you have any respiratory problems?
13. Do you have arthritis or any other muscular or skeletal problems?
14. Do you have any neurological problems or disorders?
15. Do you have any bleeding disorders?

If you answered "yes" to any of the questions above, or if there is any additional health information that would be helpful for us to be aware of during the program, briefly describe below. Use a separate sheet if necessary.

MEDICAL TREATMENT AUTHORIZATION

In the event of illness, injury, or other medical emergency, I hereby grant Virginia State University or any of its representatives, full authority to take any action deemed necessary to protect my mental or physical health and safety, at my expense, and to secure necessary treatment, including placing me under the care of a doctor or in a hospital or any place for medical examination or treatment, the administration of an anesthetic and surgery, and the administration of medication as may be prescribed by a doctor. I further agree that I may be returned to the United States at my expense. I agree that if Virginia State University makes any payments on my behalf, I will reimburse the University regardless of whether I deem the payments to be medically necessary. I hereby assume all responsibility for all medical expenses that I may incur while abroad including the costs of my evacuation or return for medical or other reasons. I authorize Virginia State University to contact my parents or guardians about my physical or mental health while I am abroad if the University deems it advisable to do so.

I understand and agree that Virginia State University is not obligated to secure or pay for medical treatment on my behalf and cannot guarantee the quality of any such treatment. I hereby release Virginia State University and its employees from any and all liability, claims and causes of actions that might arise as a result of the exercise of their authority under this agreement.

I certify that all responses made on this Health Disclosure Form are true and accurate, and that I will notify the Office for International Education of any relevant changes in my health that occur prior to or during the term of the Program. I understand that this form is for information purposes only and in no way obligates Virginia State University, the Program Director, or faculty leader to take any responsibility for my health.

Participant's Signature

Date

If the participant is under 18 years of age, a parent or legal guardian must read and sign below.

I am the parent or legal guardian of the above student. I have read and understand the foregoing Health Report and Release Form. I am willing to be legally responsible for the obligations and liabilities of the student as described in the Health Report and Release Form and I agree, for myself and for the student, to be bound by its terms.

Signature of Parent or Legal Guardian

Date