

Longwood University

Study Abroad



HEALTH REPORT AND RELEASE

Please complete this form and submit to the Office of International Affairs or to your faculty program leader at least two months prior to departure.

Please type or print in very clear block letters using black ink

Your 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 Longwood University International Affairs Office at (434) 395-2158 or goetzla@longwood.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 Longwood 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 aboard. The information provided will be treated confidentially. However, you agree that this information will be used by the Director of International Affairs and given to 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. Failure to disclose any condition or medication is grounds for your dismissal from the program; you will be responsible for the resulting academic and monetary consequences.

I, _____ (print name) hereby give my permission for the directors of the Student Health and Wellness Center and the Counseling Center at Longwood University to release my Longwood University health records to the Director of International Affairs 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

MEDICAL HISTORY

If you answer “yes” to any of the questions below, or if there is any additional health information that would be helpful for us to be aware of during the program, please describe in the spaces below. Use a separate sheet if necessary.

	Sex: <i>(Circle one)</i>	Male	Female
1. Do you have physical limitations?		Yes	No
2. Have you ever been treated for an emotional disorder?		Yes	No
3. Are you currently being treated for any psychological or emotional condition?		Yes	No
4. Are you currently taking any prescription medications?		Yes	No
5. Do you anticipate needing any health care or counseling while abroad?		Yes	No
6. Are you a diabetic?		Yes	No
7. Do you have any dietary restrictions?		Yes	No
8. Do you have epilepsy or other seizure disorders?		Yes	No
9. Do you have asthma?		Yes	No
10. Do you have any allergies to food, medicines, plants or animals?		Yes	No
11. Do you have any cardiac or circulatory problems?		Yes	No
12. Do you have any respiratory problems?		Yes	No
13. Do you have arthritis or any other muscular or skeletal problems?		Yes	No
14. Do you have any neurological problems or disorders?		Yes	No
15. Do you have any bleeding disorders?		Yes	No

Allergies: _____

Medications: _____

Other: _____

INSURANCE INFORMATION

All students and faculty participating in a Longwood 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, so Longwood University provides additional insurance coverage through ISIC. You will receive a brochure outlining the coverage provided. ISIC relies on your primary insurance for some coverages. Please complete the following with your primary insurance information.

Primary Insurance Carrier and Policy Number: _____

Name of Policyholder: _____

Relationship of Policyholder to Participant: _____

MEDICAL TREATMENT AUTHORIZATION

In the event of illness, injury, or other medical emergency, I hereby grant Longwood 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 Longwood 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 Longwood 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 Longwood 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 Longwood University, its board, officers, employees and agents 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 University 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 the University or Program Director 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 this 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

Office of International Affairs

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