



THE INFORMATION ON THIS FORM WILL NOT BE USED TO DENY PARTICIPATION IN THE PROGRAM. IT WILL ONLY BE USED IN CASE OF EMERGENCY. PLEASE FILL OUT THIS FORM COMPLETELY AND ANSWER ALL QUESTIONS TRUTHFULLY.

Regarding disability, it is your responsibility to provide the necessary documentation of disability and to give ISA staff adequate notice when requesting accommodations that require preparation. University facilities and housing in other countries may not meet American standards of accessibility for persons with disabilities. By filling out this form completely and answering all questions truthfully, ISA will be able to determine whether your selected program is able to provide you with necessary accommodations. Should your particular program not be able to offer the necessary accommodations, ISA will attempt to offer you an alternative placement. ISA cannot guarantee that all programs will be able to provide necessary accommodations.

PARTICIPANT INFORMATION

PARTICIPANT NAME

PROGRAM TERM AND DATES

SS

DOB AGE

COUNTRY OF BIRTH SEX

PERSONAL AND FAMILY HISTORY

1. ARE ALL OF YOUR PARENTS AND SIBLINGS ALIVE? YES NO IF NO, PLEASE GIVE CAUSE OF DEATH, RELATIONSHIP TO YOU AND ANY OTHER SIGNIFICANT HEALTH PROBLEMS THEY MAY HAVE HAD.

2. HAVE YOU OR A RELATIVE (EG. PARENTS, SIBLINGS OR GRANDPARENTS) EXPERIENCED ANY OF THE FOLLOWING?

Table with 2 columns: SELF, RELATIVE. Rows include HEART ATTACK, STROKE; HIGH BLOOD PRESSURE; HIGH CHOLESTEROL; DIABETES; CANCER; ALCOHOL/DRUG ABUSE; EMOTIONAL DISORDER; HEREDITARY DISORDER.

3. HAVE YOU HAD MAJOR SURGERY? ATTACH ADDITIONAL PAGES AS NEEDED. YES NO

4. HAVE YOU EVER RECEIVED MEDICAL OR PSYCHIATRIC AID OR LONG-TERM COUNSELING OR BEEN HOSPITALIZED FOR EMOTIONAL PROBLEMS (I.E. EMOTIONAL/EATING DISORDERS, DRUG/ALCOHOL PROBLEMS)? YES NO

IF YOUR ANSWER TO QUESTION 4 IS YES, YOU MUST COMPLETE PAGE 5 IN FULL AND RETURN TO ISA.

5. DO YOU HAVE ANY ON-GOING MEDICAL CONDITION AND/OR MEDICATIONS? ATTACH ADDITIONAL PAGES AS NEEDED. YES NO

DIAGNOSIS & TREATMENT

6. ALLERGY HISTORY IF YES, PLEASE NAME AND DESCRIBE REACTION

INHALANTS YES NO

FOOD INTOLERANCE YES NO

INSECTS YES NO

OTHER YES NO

7. DO YOU HAVE A DISABILITY OR CONDITION THAT MAY REQUIRE SPECIAL ACCOMODATIONS SUCH AS FIRST FLOOR HOUSING, ALTERNATIVE TRANSPORTATION, ETC? ATTACH NECESSARY DOCUMENTATION AS NEEDED. YES NO

DESCRIBE

8. DO YOU HAVE ANY LEARNING DISORDERS THAT REQUIRE SPECIAL ACCOMMODATIONS SUCH AS EXTENDED TEST TIME, SEPARATE TESTING ROOM, ETC? ATTACH DOCUMENTATION FROM HOME UNIVERSITY WITH DETAILS. YES NO

9. DO YOU HAVE ANY MEDICAL INFORMATION YOU WOULD LIKE US TO DISCLOSE TO YOUR HOUSING/HOST FAMILY? YES NO

10. CHILDHOOD ILLNESS: CHICKEN POX YES NO; MEASLES YES NO; MUMPS YES NO

FAMILY DOCTOR

NAME

PHONE

## PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME	RELATIONSHIP	WORK PHONE
ADDRESS		HOME PHONE
CITY	STATE	ZIP
		EMAIL

### IMMUNIZATIONS

I accept complete and absolute responsibility and liability for ensuring that I am properly immunized against conditions and diseases for the countries to which I am traveling. I represent and warrant that I am informed what the proper immunizations are for the countries. I further represent and warrant that I have confirmed with my physician and/or the U.S. Department of Health and Human Services – Centers for Disease Control and Prevention's website ([wwwn.cdc.gov/travel/](http://wwwn.cdc.gov/travel/)) for updates and recommendations regarding immunizations for the countries to which I am traveling. I further represent and warrant that I have received all necessary and recommended immunizations.

### EMOTIONAL AND PHYSICAL STRESS

Living and studying in a foreign environment may create unexpected physical and emotional stress, which may exacerbate otherwise mild disorders. I understand that it is important that I am able to adjust to potentially dramatic changes in climate, diet, living conditions and studying conditions that may be seriously disruptive to accustomed patterns of behavior. I understand that I should never assume that going abroad to study would provide an antidote to health problems experienced at home. I understand that if I fail to inform ISA about a medical condition, medication or medical treatment that I have received/am receiving and there are related problems during the program, it may result in my being dismissed from the program.

### MEDICATIONS & TRAVELING ABROAD

If you regularly take prescription medications, bring a supply to last throughout your time abroad. Bring a letter (in your carry-on luggage) from your health care professional listing your medications, their dosage, their generic name, and a description of the condition being treated, and give your ISA directors a copy of the letter upon arrival. This letter could be helpful in an emergency. Make sure all drugs you take with you are in the original pharmacy containers and are clearly labeled. You should carry copies of the prescriptions to avoid problems with Customs. Be sure to carry all prescriptions, medicines, and related paperwork in your carry-on luggage.

In the case of narcotic medicines, you may not be able to carry additional supplies because of possible Customs difficulties. Instead, bring a prescription with the drug's generic name and a letter from your health care professional describing your condition.

Most countries have very strict regulations on having medications shipped abroad, and in many countries it is illegal to ship it altogether. Check with the postal service and customs office well in advance. It is imperative that you discuss with your health care professional in the U.S. ahead of time how you will get medications that you need in your host country if you are not able to bring a full supply with you.

### PARTICIPANT AUTHORIZATION AND RELEASE

I authorize International Studies Abroad, Inc. to seek and to obtain medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by duly licensed healthcare professional. I am aware that due to the nature of traveling abroad, it may not be possible to obtain the same quality of health care that I would receive if I were treated in the United States. I freely, knowingly and willingly choose to participate in the program and assume the associated risks and will take due care during such participation.

I hereby release and discharge, indemnify and hold harmless International Studies Abroad, Inc., its governing board, officers, employees, agents, interns, and any other persons or entities acting on its behalf, and the successors and assigns for any and all of the aforementioned persons and entities, against all claims, demands and causes of action whatsoever, either in law or equity, relating to the diagnosis and/or treatment of any ailment, condition, disease, disability or bodily and psychological injury arising from my participation in the ISA program. I understand that I am solely responsible for any costs arising out of the diagnosis and/or treatment of any ailment, condition, disease, disability or bodily and psychological injury sustained through my participation in normal or unusual acts associated with the ISA program. I represent and warrant that I am in good health, and affirm that my participation in the International Studies Abroad, Inc. program will in no way aggravate any condition(s) present.

**BY SIGNING BELOW I CERTIFY THAT THE INFORMATION IS TRUE AND CORRECT. FURTHER, I AGREE TO BE BOUND BY THE TERMS AND CONDITIONS OF THE AUTHORIZATION AND RELEASE.**

<b>X</b>	_____	_____	_____
PARTICIPANT SIGNATURE	PRINTED NAME OF PARTICIPANT	DATE	
<b>X</b>	_____	_____	_____
PARENT/GUARDIAN SIGNATURE	PRINTED NAME	DATE	
PARENT/GUARDIAN SIGNATURE (IF PARTICIPANT IS UNDER 18)			

\_\_\_\_\_  
STUDENT NAME\_\_\_\_\_  
TERM AND YEAR OF PROGRAM ABROAD\_\_\_\_\_  
US UNIVERSITY\_\_\_\_\_  
CITY AND COUNTRY OF PROGRAM ABROAD**RIGORS OF STUDY ABROAD**

ALL participants must complete this form to demonstrate they are cleared, health wise, to participate in the ISA program. The Health Clearance form must be signed and returned to the ISA Office, before the participant is allowed to participate in an ISA program. Copies of the Medical History and Health Clearance forms are to be retained by both the healthcare professional and the participant as a confidential medical record.

**TO THE PHYSICIAN/HEALTHCARE PROFESSIONAL:**

The participant named on this Form has been selected to participate in a program of study abroad. Depending on the program, participants may spend from a month to a full year in residence abroad. Living and studying in a foreign environment may create unexpected physical and emotional stress, which may exacerbate otherwise mild disorders. It is important that all participants be able to adjust to potentially dramatic changes in climate, diet, living conditions and studying conditions that may be seriously disruptive to accustomed patterns of behavior. One should never assume that going abroad to study would provide an antidote to health problems experienced at home. Failure to disclose or inform ISA of medication or medical treatment potentially increases the risk the participant faces while studying abroad.

**ALL PARTICIPANTS MUST BE GRANTED A HEALTH CLEARANCE TO STUDY ABROAD WITH ISA.**

This clearance must include the following steps:

1. The participant must present you a fully completed Medical History form. Please review this form with the participant for accuracy and completeness. You do not need to perform a physical examination unless requested by the participant, but you must discuss the participant's health history thoroughly, paying particular attention to immunizations that may be needed, any allergies the participant may have, and all currently active health issues.

2. Pay special attention to any emotional/psychological problems and the medications the participant is taking. ISA is especially concerned for the well being of participants who have been diagnosed as anorexic or bulimic, bi-polar disorders or depression that requires medication; these conditions may increase the risk to life-threatening levels in a foreign environment. Participants may be cleared with these conditions provided they are in compliance with and stabilized on their medication.

3. Please impress on the participant the need to ascertain the availability of medications in the country to which they are traveling and/or assure that they have a supply of any necessary medication sufficient to last for the entire period they will be abroad. The need for any counseling or laboratory testing while abroad should also be disclosed so that ISA may determine the availability of adequate facilities at the program site.

4. Please describe any physical or learning disabilities the participant may have. Please note on this form any facilities/services required to accommodate such disabilities.

Participants may be cleared for participation so long as, in the opinion of the examining healthcare professional, any condition they may have is under control and they have been stabilized on their medication for a reasonable period of time. If a specialist for a serious ongoing medical or psychiatric condition is currently seeing the participant, the specialist should also approve and sign this clearance form.



IF YOU ANSWERED YES TO NUMBER 4 ON PAGE 1, YOU ARE REQUIRED TO COMPLETE THIS PAGE IN FULL AND RETURN IT TO ISA.  
IF YOU ANSWERED NO TO NUMBER 4 ON PAGE 1, YOU ARE NOT REQUIRED TO COMPLETE THIS PAGE.

### MEDICATIONS AND ALCOHOL

During my time abroad, I agree to take all medications as prescribed by my mental health practitioner, and not to partake in any activities that will lessen the effectiveness of my prescribed medication. I understand that the consumption of alcohol significantly increases the likelihood of patients' non-compliance with their health practitioner's recommendations and prescriptions. Furthermore, I understand that the consumption of alcohol can interfere or be potentially dangerous when used in conjunction with most psychiatric drugs. I thus agree to fully comply with any pharmaceutical recommendations that warn me against the dangers of consuming alcohol while taking my prescriptions. I understand that any disregard of these recommendations and warnings will constitute a breach of the ISA Code of Conduct, and I promise to cooperate with any decision by ISA to expel me from the program should I break such rules.

### DOCTOR/SPECIALIST REFERRAL

It is required by ISA that you have a doctor/specialist contact in the US with whom you can communicate on an on-going basis regarding your condition, should you have a recurrence or worsening of symptoms which may require sessions of long-distance therapy or counseling. Due to your previous condition(s), it is required that you arrange the option of long-distance therapy in advance of your program with your doctor/specialist of choice, and that you provide ISA with the contact details and confirming signature of that doctor/specialist

The name and details of my doctor/specialist contact, with whom I have pre-arranged this long-distance therapy or counseling is included below. I, the undersigned, authorize my doctor/specialist, \_\_\_\_\_, to communicate regarding my condition with International Studies Abroad, Inc., who will be organizing my study abroad program.

I understand that I have the right not to consent to the release of this information and that this consent shall remain in effect until revoked by me, in writing, and delivered to International Studies Abroad, Inc., but that any such revocation shall not affect disclosures previously made between my doctor/specialist and International Studies Abroad, Inc. prior to the receipt of any such written revocation.

*Please be advised that the insurance coverage through ACE American Insurance will not cover long-distance therapy or counseling, so you are encouraged to look into the coverage available through your US-based insurance to determine how these sessions may be covered.*

**X** \_\_\_\_\_  
PARTICIPANT SIGNATURE

\_\_\_\_\_  
PRINTED NAME OF PARTICIPANT

\_\_\_\_\_  
DATE

**X** \_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
PRINTED NAME OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

PARENT/GUARDIAN SIGNATURE (IF PARTICIPANT IS UNDER 18)

I HAVE READ TO THE SECTION ABOVE TITLED "DOCTOR/SPECIALIST REFERRAL", AND I AGREE TO THE CONTACT DESCRIBED, SHOULD IT BE NECESSARY DURING THE TERM THAT THE STUDENT IS ABROAD ON THE PROGRAM WITH INTERNATIONAL STUDIES ABROAD, INC.

**X** \_\_\_\_\_  
SIGNATURE OF DOCTOR/SPECIALIST

\_\_\_\_\_  
PRINTED NAME OF DOCTOR/SPECIALIST

\_\_\_\_\_  
DATE

( ) \_\_\_\_\_  
PHONE NUMBER