STATE UNIVERSITY OF NEW YORK Overseas Academic Programs

STUDENT HEALTH INFORMATION

				Please type or pri	int in ink.			
Nam	ne:							
		Last		First		Middle		
Proc	gram:							
		Location Abr	oad	Approximate	dates of the program	Administ	ering SUN	VΥ
own with abro	care, thoug yourself and ad. Indicatir	h SUNY and d prepare acong that you ha	the organization	on hosting you over questions that follo	ntial. Be aware that you rseas will try to provide w will help guide you in s to assist you in detern	assistance. For preparing for	Please be your stay	honest y
1.	eating diso stress caus to see you	orders), that r sed by chang r health care	might require tr les in culture, c provider to disc	eatment abroad, o limate, diet or exer cuss your care.	al or emotional condition or that might be exacer cise? If yes, explain be	bated by the	□ Yes	□ No
2.	recomment - may hat - may hat - is avail	ded for visiting the been property ave been property able on the l	ng the program vided by SUNY vided by the pr JS Center for D	site by reviewing in the site by reviewing in the site;	d Prevention website; a	and	□ Yes	□ No
3.	what you n care provice restrictions	nay need to r ler for assista below so we	manage your co ance in plannin e can inform ov	ondition or restriction g for your care. Yo	ietary restrictions? If yeons. If needed, see you u may list any allergies However, SUNY can or ure.	r health or dietary	□ Yes	□ No
4.	while abroa	ad? If yes, lis usider how yo o develop a p	t medication na bu will have accolan for manag	ame and purpose. ess to the medical	ied any medications you tion you need and cons while abroad. Dependir	ult with your	□Yes	□ No
5.	(Disclosu accommod that the Am States. Th accommod	re of disabil lations? If yes nericans with e Administer lations you m	lities is option s, provide a des Disabilities Act ring Campus v nay want; howe	al) Do you have a scription of desired (ADA) does not ap will assist you, to ever, it may not be	disability for which you accommodations. Plea ply outside the borders the extent possible, to able to obtain the accorde overseas program.	se be aware of the United o obtain the	□ Yes	□ No
Co	ntinued on r	next page.						

Student Declaration

I grant the State University of New York, its employees, agents and overseas partners permission to share information 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 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 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						
If you answered yes to 1, or 4, or no to 2 please make an appoint provider to review your medical history and travel plans and h							
To the Treating Clinician: Please review the student's medical history, discoverseas study plans and sign below. A physical exam is not required information to advise the student.							
I have reviewed this student's medical history and examination with him/vaccinations and medications that may be required, and developed a treatment p	her consulted with him/her about						

Printed Name of Provider

condition during the overseas program, if needed. (Attach pages as necessary.)

Address and Phone Number of Provider

Signature of Provider