GLOBAL INITIATIVES
Study Abroad

Student Health Information Form

When traveling outside of the US, you may have difficulty accessing particular medications or health care services. To help ensure your wellbeing while studying abroad, we encourage all UA students studying abroad to share important medical, mental health or disability-related information with their program's staff. Release of critical health-related information may expedite treatment while abroad.

While we ask that you complete this form as soon as possible, you will be able to complete at any point before or during your Study Abroad program.

In addition to your travel screening at Campus Health, if you have a disability, we encourage you to discuss potential accommodations with an Access Consultant at the Disability Resource Center: https://drc.arizona.edu/students.

RELEASE OF INFORMATION: I authorize the release of information in this report, to the study abroad program staff for my faculty-led program(s). I acknowledge and agree that nothing in the foregoing statement or authorization to release information shall be construed as creating any obligation or duty on the part of UA to obtain medical care on my behalf.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I may revoke this release at any time by providing written notice of such revocation to UA Study Abroad except to the extent that action based on this authorization has already been taken. This authorization is good for one year from the date I sign this release.

_____ /_____

Signature of Student / Date

(Important: If the participant is under 18 years old, the parent or legal guardian must also sign below):

_____ /_____

Signature of Parent or Legal Guardian / Date

STUDENT AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT: I hereby authorize the faculty/advisor and/or attending physician to seek emergency treatment on my behalf if, in their opinion, emergency treatment is necessary to safeguard my health. I acknowledge and agree that nothing in the foregoing statement or authorization to release information shall be construed as creating any obligation or duty on the part of UA to obtain medical care on my behalf. I agree to pay for any charges for emergency medical treatment that are not covered by my personal health insurance.

_____ /_____

Signature of Student / Date

(Important: If the participant is under 18 years old, the parent or legal guardian must also sign below):

_____ / _____

Signature of Parent or Legal Guardian / Date

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Student Health Information *(please continue on a separate sheet if necessary)*

*Name:*_____ *Program:*_____ *Term:*_____

1. Are you currently taking any medication? Please list below and explain:

_____

_____

_____

2. Do you have any allergies to medications, foods, insects, etc.? Please indicate: (List)

_____

_____

_____

3. Is there anything specific that you would like your faculty advisor to know about a medical or mental health condition or disability?

_____

_____

_____

4. Do you use any health related devices or equipment where you may need assistance should the device/equipment need repair or replacement?

_____

_____

_____

5. Anything else you would like us to know about your health?

_____

_____

_____