Print Form

Wake Forest University
Health Form for Participation in International Travel

Program Name | **Semester/Term Abroad**

Last | **First** | **Middle**

Birth Date | **Marital Status** | **Sex**

HEALTH INSURANCE INFORMATION REQUIRED:

Will your current health insurance policy cover you in the country to which you are going?

☐ Yes ☐ No*

*If your current health insurance policy does not provide coverage while you are abroad, you must purchase health insurance specifically for that purpose. Medical evacuation and repatriation coverage is recommended.

AUTHORIZATION AND CONSENT:

I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person, and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physician or whomever he or she may designate may evaluation and treat all other injuries or illnesses for which help is sought. In the case of a minor (under 18 years of age) this treatment may proceed without prior notification of the undersigned parent or guardian, although every attempt will be made to notify the parent or guardian in the event of such an injury or illness. I also agree that needed immunizations may be administered. I further agree that any medical information may be released to or by other health care providers who may be providing care or who are knowledgeable of my medical history.

Are you capable of participation in a full program of activities? ☐ Yes ☐ No

Are you now under treatment with medication for any medical or emotional condition?
☐ Yes ☐ No

Is there anything additional about your health that we should know? ☐ Yes ☐ No

If "Yes," please expain

Do you have a disability that may require an academic or another type of accommodation to enable you to participate in this program? ☐ Yes ☐ No

If yes, please contact Van D. Westervelt, PhD or Michael Shuman, MEd at the Learning Assistance Center, P.O. Box 7283 Reynolda Station, Winston-Salem, NC 27109, (336) 758-5929, to make your accommodation request.

(continued)

PERSONAL HISTORY - PLEASE ANSWER ALL QUESTIONS.
Comment on all positive answers under "Remarks."

HAVE YOU HAD?	Yes
Allergy to:	
Penicillin	☐
Sulfonamides	☐
Peanuts	☐
Bees, wasps	☐
Other (specify below	☐
Infectious mononucleosis	☐
Tropical disease - specify	☐
Chicken pox/Varicella	☐
Respiratory disorders including asthma	☐
High blood pressure	☐
Diabetes, thyroid, endocrine problems	☐
Stomach or intestinal disorders	☐
Blood disorders including anemia	☐
Headaches/migraines	☐
Menstrual cycle disorders	☐
Current prescription medicines - list	☐
Current vitamins or supplements - list	☐

HAVE YOU HAD	Yes
Surgery or serious injury	☐
Chronic medical condition - specify	☐
Vision, corrective lens	☐
Cancer	☐
Heart disease	☐
Serious head injury	☐
Hepatitis B	☐
Hepatitis C	☐
Kidney disease	☐
Neurological disorder	☐
Depression/anxiety	☐
Other psychological problem	☐
Seizure disorder	
Organ loss (list below)	☐

Current non-prescription medicines (list below)	☐

Remarks

Signature of Faculty/Staff/Student_________________________ **Date**__________________

Signature of minor's (under 18) parent/guardian_________________________ **Date**____________

Please return this form completed and signed to the WFU Center for Global Programs & Studies, 116 Reynolda Hall; or mail to:

WFU Center for Global Programs & Studies
P.O Box 7385
Winston-Salem, NC 27109