Part 1 of 2: Student Self-Assessment
To be completed and signed by student

Student name: **Program name and country**:

_____ _____

It is important that **(Penn Abroad)** be made aware of medical or emotional conditions, past or current, as even mild physical or psychological disorders can become serious under the stresses of life in an unfamiliar environment. The information provided by you and your health provider(s) will remain confidential and will be shared only on a need-to-know basis with program staff and faculty, Penn Student Health Service, or appropriate health providers abroad if pertinent to your well-being. Your ability to participate will not be affected on the basis of either a physical or mental health condition unless it is of such a serious nature or degree as to prevent your successful participation in the program.

☐ Yes ☐ No 1. Are you currently being treated, or have you been treated within the last five (5) years for a physical health condition, injury or disease? **(If yes, please describe)**

☐ Yes ☐ No 2. Are you currently being treated, or have you been treated within the last five (5) years, for a mental health condition (e.g. alcohol and/or other substance use disorder, depression, anxiety, eating disorder, or condition related to loss or grief)? **(If yes, please describe)**

☐ Yes ☐ No 3a. Do you have a health condition or disability that may require reasonable accommodations to fully participate in a program abroad?
3b. If yes, please consult with Student Disabilities Services about accommodations abroad. Note: Penn cannot guarantee that services or accommodations are available abroad.

☐ Yes ☐ No 4. Do you have any allergies? **(If yes, please describe)**

☐ Yes ☐ No 5. Are you taking any medications? If yes, please list with condition being treated and include medication(s) you carry for possible use (e.g. inhaler, bee sting kit).

☐ Yes ☐ No 6. Are you a vegetarian or are you on a restricted diet? **(If yes, please describe)**

☐ Yes ☐ No 7. Is there any additional information regarding your health or well-being that would be helpful for the program to be aware of during your experience abroad? **(If yes, please describe)**

I certify that all responses made on this health information form are complete, true and accurate, and that I will notify **Penn Abroad** hereafter of any relevant changes in my health that occur prior to departure. I understand that any false or inaccurate information may affect my program participation. With my signature, I authorize the release of any medical information that, in the opinion of my health care provider, may be relevant to my participation on a Penn Abroad program.

Student signature: _____ **Date**: _____

Please continue to Part 2

Penn Abroad

Part 2 of 2: Health Care Provider Evaluation
To be completed and signed by health care provider

Student name: **Program name and country:**

_____ _____

Duration of program: _____

TO THE HEALTH CARE PROVIDER:
Thank you for taking the time to meet with this student who has plans to travel abroad on a University of Pennsylvania program. You are being asked to evaluate this student's physical and mental health for participation in the abovementioned study abroad program

Please keep in mind that living and studying in an unfamiliar environment can trigger physical and emotional stress and exacerbate current health issues. Medications and reliable health care may not be accessible to the student in his/her host country.

To be completed by health care provider (Check all that apply):

☐ I have read the **Student Self-Assessment** (part 1 of this form) and met with the student to discuss his/her health status as it relates to the intended international travel experience.

☐ This student has a health condition where the administration of a live vaccine is contraindicated.

☐ I have expressed concerns to the student regarding his/her ability to successfully participate in a study abroad program due to a physical or mental health condition and encouraged the student to further discuss this condition with _____ (e.g. health care specialist, mental health counselor, Student Disabilities Services, trip leader, etc.) well in advance of the departure date.

Health care provider's name: _____**Title:**_____

Address: _____**Phone:** _____

Signature: _____**Date**: _____

1. ***This form requires the student to meet with a healthcare provider <u>in-person</u> for consultation regarding their travel.***
2. ***Please stamp or attach business card and return form directly to student.***
3. ***Forms signed by family members will not be accepted.***