Penn Abroad Health Information Form: Part 1 of 2
To be completed by student and signed by health care provider

Your name: __________________________ Program name and country: __________________________

It is important that Penn Abroad be made aware of medical or emotional problems, 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 physician(s) will remain confidential and will be shared with program staff, faculty, Penn Student Health Services, or appropriate professionals, if pertinent to your well being. Your application will not be rejected on the basis of either a physical or an emotional 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 in generally good physical condition? (If no, explain)

☐ Yes  ☐ No  2. Have you ever been or are you currently being treated for any psychological or emotional problems?

☐ Yes  ☐ No  2b. If yes, have you discussed an ongoing plan for treatment while abroad, if necessary?

☐ Yes  ☐ No  3. Do you have a physical or documented learning disability?

☐ Yes  ☐ No  3b. If yes, have you already consulted with Student Disability Services about receiving special accommodations abroad?

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

☐ Yes  ☐ No  5. Are you taking any medications? (If yes, explain for what ailment)

☐ Yes  ☐ No  6. Have you had any major injuries, diseases, or ailments in the last five years? (If yes, explain)

☐ Yes  ☐ No  7. Are you a vegetarian or are you on a restricted diet? (If yes, explain)

☐ Yes  ☐ No  8. Is there any additional information regarding your health or well being that we should know about before you study abroad? (If yes, explain)

I certify that all responses made on this health information form are true and accurate, and that I will notify Penn Abroad hereafter of any relevant changes in my health that occur prior to the start of my program.

Your signature: __________________________ Date: ______________

Health care provider’s signature: __________________________ Date: ______________

Penn Abroad does not accept forms signed by family members. Please continue to Part 2

Deadlines: May 1 for fall semester and academic year; December 1 for spring semester

3701 Chestnut Street  Suite 1W  Philadelphia, PA 19104-3199
Tel 215.898.9073  Fax 215.898.2622  http://global.upenn.edu/pennabroad
Penn Abroad Health Information Form: Part 2 of 2

A. TO THE APPLICANT: Please authorize by your signature below the release of any medical information that may be relevant in the opinion of your health care provider to your participation in a study abroad program.

Your name: ____________________________________________________________

Signature: ____________________________________

Program name and country: ________________________________________________

Date: ________________________________

B. TO THE HEALTH CARE PROVIDER:

1. In order to complete this form, you must have seen the student within the past year. What is the date of your most recent appointment with the student? ________________________________

2. Please indicate if the student named above has:

   • a history of chronic or disabling physical conditions  □ Yes  □ No  (If yes, explain)

   • any allergies that may require either continuing or emergency treatment  □ Yes  □ No  (If yes, explain)

   • any special dietary problem or any other physical or emotional condition which might affect his/her well-being or that of fellow students while participating in the Penn Abroad program.  □ Yes  □ No  (If yes, explain)

2b. If you answered yes to any of the questions in #2, please describe the ongoing plan for treatment abroad you discussed with the student.

3. List the generic names for any prescription medicine the student requires that may not be readily obtainable abroad.

4. Please address any concerns you may have about the student studying abroad at this location.

5. Please check all statements that apply:

   □ The student is medically cleared to study abroad.

   □ The student needs further clearance from an outside medical provider. (If yes, explain)

   □ The student needs further clearance from their personal mental health provider. (If yes, explain)

   □ I recommend that the student go to Penn Student Health or another travel clinic for a travel consultation.

Health care provider's name: ____________________________________________

Address: __________________________________________________________________

Phone: ________________________________

Signature: ________________________________

Date: ________________________________

Penn Abroad does not accept forms signed by family members. Please stamp or attach your business card and return this form to the student, or directly to Penn Abroad.

Deadlines: May 1 for fall semester and academic year; December 1 for spring semester

3701 Chestnut Street Suite 1W Philadelphia, PA 19104-3199
Tel 215.898.9073 Fax 215.898.2622 http://global.upenn.edu/pennabroad