Lehigh University
Study Abroad Faculty-Led Programs

Health Information Form

General and Emergency Contact Information

Please note: Disclosure of the following information is voluntary. However, it is in the best interest of each program participant to disclose any physical, psychological or other medical condition that may affect their health, wellness or safety during the trip abroad. This information allows us to identify and discuss your needs, as well as provide optimal care to participants if the need arises. Confidential physical health and mental health counseling is available at the Health and Wellness Center (ext. 3870) and at Counseling and Psychological Services (ext. 3880).

Name: ________________________________ Lehigh Student ID: _______________

Country of Study/Service: ________________________

Emergency Contact:
Name: ___________________________ Relationship: ___________________
Home Tel.: __________________ Bus. Tel.: _________________ Cell: _____________
Email address: _______________________

Name: ___________________________ Relationship: _________________________
Home Tel.: __________________ Bus. Tel.: _________________ Cell: _____________
Email address: _______________________

☐ **I Decline to Disclose the Following Information.**

Health/Psychological Care Professional Contact Information:
Name: ____
Address: ____
City: _________________________________ State: _____________ Zip: ____________
Telephone: ________________________ Fax: _________________________________

Clinical History

Are you currently under medical treatment? __ yes __ no
Do you have a chronic medical condition (asthma, diabetes, IBS, Crohn's, etc.)?
__ yes __ no If 'yes' please identify the condition(s) below:
____
____
____

Have you had any psychological, psychiatric, or personal issues (including eating disorders, substance abuse, family concerns) during the past five (5) years for which you have sought professional services? __ yes __ no
If yes, please describe the circumstances:
____
____
____

Are you currently taking any medications? __ yes __ no If yes, please list name, dosage, prescribing clinician and, if not listed above, contact information for that clinician.

NOTE: Please list all medications you take regularly, including those treating physical conditions (including any allergies) and psychological conditions (including depression, anxiety, or other psychological/emotional issue).

Name of medication	Dosage	Prescribing Clinician
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________
____________________	__________	________________________________

What condition(s) is (are) being treated with medication?

____

____

When did you start taking these medications?

____

____

Have you contacted your clinician and health insurance provider to obtain a sufficient dosage of this medication for the duration of your study abroad program?___Yes ___ No
If “no” please list date when this contact will be made: ______________________________

Please list any allergies to medication, food or other substances/conditions:

____

____

Please list any dietary restrictions:

____

____

Have you had any diseases, surgical operations or significant injuries within the last five (5) years that could have an effect on your participation in this program? __ yes __ no
If yes, please explain:

____

____

Have any surgical operations been recommended that could have an effect on your participation in this program? __ yes __ no If yes, please explain:

____

____

Do you plan to have any surgical operations between now and your date of departure?
__ yes __ no If yes, please explain:

____

____

Is there anything else about your health or medical history that may be a factor should there be an emergency? __ yes __ no If yes, please explain:

____

____

Learning Disabilities

Do you have any conditions (including physical impairments or learning disabilities) that might restrict your mobility or require special facilities or accommodation while abroad?
__ yes __ no
Have you discussed these issues with your program coordinator?
__ yes __ no
If 'no', would you be willing to be contacted by your program coordinator to make arrangements to accommodate your needs while abroad? __ yes __ no

Authorization Statement

I hereby authorize Lehigh University to release information from my medical history, including but not limited to medical records, upon the request of the program leaders.
I understand that the Faculty/TA/GA will not request any information from my medical records unless a situation arises while I am a participant in the intersession trip that makes it necessary to have the information pertinent to my safety or health.
I further understand that any information obtained from my medical records by the Faculty-led program leadership will be destroyed upon the completion of the study abroad program.
I understand that, if I have a medical, psychiatric or psychological condition that requires or has required treatment, I must discuss my situation with my clinician.

I certify that the information on this Health Information Form is true and correct, and I will notify the Faculty-led program leadership hereafter of any significant or relevant changes in my health that occur prior to or during the study abroad program.

Student's Signature: ____

Printed Name: __________________________ Date: ___________________________