Office of Study Abroad
Old Main, Room 102

Study Abroad Programs Health Form

This form is intended to determine your health history and any special medical needs you may have while you study abroad. Information provided will be treated confidentially, and any information considered important will be forwarded to your faculty leader or the host institution for the purpose of serving you as promptly and appropriately as possible should you require medical or counseling services during your time abroad.

First Name, Last Name:			
MU ID Number:	**E-mail:**		**Phone:**
Age:	**Gender:**	**Height:**	**Weight:**
Generally, are you in good physical condition? YES ☐ NO ☐	If NO, please explain.		
Are you currently being treated for any physical condition? YES ☐ NO ☐	If YES, please explain.		
Are you taking any medications? YES ☐ NO ☐	If YES, please explain.		
Do you have any allergies to foods, medications, environmental factors, insects, etc.? YES ☐ NO ☐	If YES, please explain.		

Do you have or have you ever been treated for:	YES	NO
Asthma or other Respiratory Problems		
Cardiac problems		
Diabetes		
Neurological Disorders		
Psychiatric Disorders (including eating disorders)		
Other Problems (if YES, please explain below)		

I certify that all responses made on this Health Form are true and accurate. I will notify the Office of Study Abroad hereafter of any relevant changes in my health that occur prior to/or during the program. I understand that this form is for information purposes only and in no way implies that Marshall University takes responsibility for my health.

Student Signature: _____ **Date:** _____