

758-5929, to make your accommodation request.

on how to obtain documentation.

## SELF-ASSESSMENT HEALTH FORM

FOR PARTICIPATION IN STUDY ABROAD/STUDY AWAY

LAST NAME	FIRST NAME	MIDDLE NAME	SEX	
MARITAL STATUS		DATE OF BIRTH (MM/DD/YYYY)		
PROGRAM NAME		SEMESTER OR TERM ABROAD/AWAY		
HEALTH INSURANCE IN	IFORMATION (REQUIRED)			
DO YOU HAVE A HEAL' ARE TRAVELING?	TH INSURANCE POLICY THAT	F WILL PROVIDE COVERAGE IN THE COU	JNTRY TO WHICH YOU /ES □ NO*	
health insurance specif	ically for that purpose. Medic	ovide coverage while you are abroad/awa al evacuation and repatriation coverage ad Studies (GPS) for additional information	is recommended for	
Note: Students particip		programs are automatically enrolled in a	an international health	
		only covered by Medicaid will need addi te. See GPS for more information.	tional coverage if	
AUTHORIZATION AND	CONSENT			
operations and/or the a notification of the under person, if in the judgment treatment without dela evaluation and treat all age) this treatment may attempt will be made to needed immunizations	administration of necessary are resigned or any other person, ent of the physician or design y. I further agree that the att other injuries or illnesses for y proceed without prior notification of the parent or guardia may be administered. I further	ever he or she may designate may under nesthesia, in serious or major illnesses of and without obtaining consent of the under it is necessary for health care reasons ending physician or whomever he or she which help is sought. In the case of a mication of the undersigned parent or gual in in the event of such an injury or illnesser agree that any medical information materials or who are knowledgeable of my medical information.	r injuries without prior dersigned or any other to proceed with the may designate may inor (under 18 years of rdian, although every s. I also agree that my be released to or by	
ARE YOU CAPABLE OF	PARTICIPATION IN A FULL P	ROGRAM OF ACTIVITIES?	□ YES □ NO	
ARE YOU CURRENTLY	UNDER TREATMENT WITH M	IEDICATION FOR ANY MEDICAL OR EM	OTIONAL CONDITION?	
IS THERE ANYTHING A	DDITIONAL ABOUT YOUR HE	EALTH THAT WE SHOULD KNOW?	$\square$ YES $\square$ NO	
> If YES, then explain	in here:			
ENABLE YOU TO PA	ARTICIPATE IN THIS PROGRA	AN ACADEMIC OR ANOTHER TYPE OF A AM? Access, and Student Success (CLASS), 118	$\square$ YES $\square$	

> Non-Wake Forest students who have a learning accommodation should contact their home study abroad office

PERSO	NAL HISTORY			
HAVE	YOU HAD? PLEASE CHECK ALL THAT APPLY.			
	Infectious mononucleosis		Neurological disorder	
	Chicken pox/Varicella		Depression/anxiety	
_	Respiratory disorders, including asthma		Seizure disorder	
	High blood pressure		Organ loss (please specify):	
	Diabetes, thyroid, or endocrine problems	_	C. Garriero (product specifi)	
	Stomach or intestinal disorders		Tropical disease (please specify):	
	Blood disorders, including anemia		Tropical disease (please specify).	
	Headaches/migraines	_		
	Menstrual cycle disorders		Other (please specify):	
	Surgery or serious injury			
	Chronic medical condition (please specify):			
		ALLERG	Y TO:	
	Vision, corrective lens	_		
	Cancer		Penicillin	
	Heart disease		Sulfonamides	
	Serious head injury		Peanuts	
	Hepatitis B		Bees, wasps	
	Hepatitis C	Ш	Other (please specify):	
	Kidney disease			
	URRENT VITAMINS OR SUPPLEMENTS:  URRENT NON-PRESCRIPTION MEDICATIONS:			
ADDITI	ONAL REMARKS			
SIGNA	TUDE			
SIGNA	TORE			
i	NOTE: For semester study abroad students, completing the student health insurance offered through Wake Fo <b>336.758.4247</b> .			
	SIGNATURE OF PARTICIPANT		DATE	
	FOR MINORS UNDER 18: SIGNATURE OF PAREN	NT/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; or email to: <a href="mailto:studyabroad@wfu.edu">studyabroad@wfu.edu</a>