

Wake Forest University
Health Form for Participation in International Travel

Program Name		Semester/Term Abroad			
Last		First		Middle	
Birth Date		Marital Status		Sex	

HEALTH INSURANCE INFORMATION REQUIRED:

Will your current health insurance policy cover you in the country to which you are going?

Yes No*

*If your current health insurance policy does not provide coverage while you are abroad, you must purchase health insurance specifically for that purpose. Medical evacuation and repatriation coverage is recommended.

AUTHORIZATION AND CONSENT:

I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person, and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physician or whomever he or she may designate may evaluate and treat all other injuries or illnesses for which help is sought. In the case of a minor (under 18 years of age) this treatment may proceed without prior notification of the undersigned parent or guardian, although every attempt will be made to notify the parent or guardian in the event of such an injury or illness. I also agree that needed immunizations may be administered. I further agree that any medical information may be released to or by other health care providers who may be providing care or who are knowledgeable of my medical history.

Are you capable of participation in a full program of activities? Yes No

Are you now under treatment with medication for any medical or emotional condition?
 Yes No

Is there anything additional about your health that we should know? Yes No

If "Yes," please explain

Do you have a disability that may require an academic or another type of accommodation to enable you to participate in this program? Yes No

If yes, please contact Van D. Westervelt, PhD or Michael Shuman, MEd at the Learning Assistance Center, P.O. Box 7283 Reynolda Station, Winston-Salem, NC 27109, (336) 758-5929, to make your accommodation request.

(continued)

**PERSONAL HISTORY - PLEASE ANSWER ALL QUESTIONS.
Comment on all positive answers under "Remarks."**

HAVE YOU HAD?	Yes
Allergy to:	
Penicillin	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>
Peanuts	<input type="checkbox"/>
Bees, wasps	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>
Infectious mononucleosis	<input type="checkbox"/>
Tropical disease - specify	<input type="checkbox"/>
Chicken pox/Varicella	<input type="checkbox"/>
Respiratory disorders including asthma	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>
Diabetes, thyroid, endocrine problems	<input type="checkbox"/>
Stomach or intestinal disorders	<input type="checkbox"/>
Blood disorders including anemia	<input type="checkbox"/>
Headaches/migraines	<input type="checkbox"/>
Menstrual cycle disorders	<input type="checkbox"/>
Current prescription medicines - list	<input type="checkbox"/>
Current vitamins or supplements - list	<input type="checkbox"/>

HAVE YOU HAD	Yes
Surgery or serious injury	<input type="checkbox"/>
Chronic medical condition - specify	<input type="checkbox"/>
Vision, corrective lens	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>
Serious head injury	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>
Neurological disorder	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>
Other psychological problem	<input type="checkbox"/>
Seizure disorder	
Organ loss (list below)	<input type="checkbox"/>

Current non-prescription medicines (list below)	<input type="checkbox"/>
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Remarks

Signature of Faculty/Staff/Student _____ **Date** _____

****NOTE** for semester study abroad students: Completing this form does not fulfill your requirement to enroll in or waive the student health insurance offered through Wake Forest. For more information, please visit www.wfu.edu/sip or call 336.758.4247**

Signature of minor's (under 18) parent/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