UC International Programs
3134 One Edwards
Phone 513-556-4278
Fax 513- 556-2990
E-mail global@uc.edu

STUDENT HEALTH/EMERGENCY TREATMENT AUTHORIZATION

The medical review of this form and admission into a program are independent of each other. The purpose of this form is to help UC International Programs provide appropriate assistance to you should the need arise during your study abroad experience. It is important that we be aware of any medical or emotional problems, past or current, which might affect your ability to participate in an education abroad program. This information will be kept confidential in accordance with the law. Any disclosure of such information will be made only to the most appropriate individuals and with the highest level of discretion in order to protect student privacy. Relevant information will be shared with program staff, faculty, or appropriate professionals as it relates to your health and safety.

Name: _____ UCID #: _____

Sex: O Male O Female Date of Birth: ____/____/____ (Month/Date/Year) Citizenship: _____

E-mail address: _____

Current adress: _____ (Street Adress / City / State / Zip)

Local Phone: _____ Cell Phone: _____ Work Phone: _____

Name of study abroad program: _____

Country/countries of program: _____

Date and year of program: _____

This information is required to coordinate treatment in the event of a medical emergency. Answer "N/A" if not applicable.

ALLERGIES

Medical Allergy: Reaction: Treatment, if exposed:

Food or environmental allergy: Reaction: Treatment, if exposed:
(foods, dust, chemicals, household items, pollen, bee stings, etc.)

MEDICATIONS

Please list any medicines you are taking on a daily, regular, or as needed basis and indicate how often and why each medicine is taken. (See "Staying Healthy" in **Know Before You Go** for information regarding transportation and use of your medication abroad.)

Name of Medication: How often taken: For what condition: Length of time treated (approx.):

NOTE: Participants must bring an adequate supply of medications that are required on a daily or routine basis when traveling abroad.

DIETARY RESTRICTIONS

Do you have any dietary restrictions? O Yes O No

If yes, please explain: _____

Please leave this copy in booklet.

STUDENT HEALTH/EMERGENCY TREATMENT AUTHORIZATION *(continued from page 3)*

DISABILITIES

Are you registered with UC Disability Services? (If you think you may be eligible, contact them in 210 University Pavilion, 513 556-6823.)

O Yes

(If yes, please discuss your plans to study abroad with your counselor to prevent potential limitations on your options abroad.)

O No

Do you have a disability that will require accommodations while abroad?

O Yes

(If yes, you must register with UC Disability Services and meet with their staff to complete a "Study Abroad Disability Accommodation Request Form." This must be done in a reasonable timeframe so as to allow for satisfactory evaluation of the requested accommodation and adequate time to implement the accommodation, if any. If you do not disclose your disability and/or request accommodations in a timely manner, UC may not be able to assess and accommodate your needs.)

O No

ADDITIONAL HEALTH CONDITIONS

Do you have any additional health conditions other than those previously listed (such as surgeries, hospitalizations, significant injuries, chronic conditions, physical illness, psychological illness, emotional illness, etc.) that may need special consideration before or during your experience or that may affect your ability to participate in this program?

O Yes O No

If yes, you are advised to consult with your health care provider. Please supply an explanation below:

Condition(s): How often do you have symptoms? Plan for managing this condition while traveling:

_____

_____

_____

HEALTH AND EMERGENCY AGREEMENT

I authorize the release of information contained in this Student Health/Emergency Treatment Authorization form for access and review by the advising staff of UC International Programs, relevant faculty directors and the appropriate health professionals in the UC Health Services. I understand that if I have not turned in this form in a timely manner, there may be insufficient time for the directors to review this information. If further medical information is required, I understand that I will be contacted by a health care professional in the UC Health Services who will ask for a specific release to my treating health care professional(s), and/or clarify medical information with me directly. I understand that if this information is pertinent to my health and safety abroad, it may be discussed in a confidential manner with the UC International Programs advisor, the faculty director, host family, and the host institution's resident director.

In the event that I need emergency medical care, hospitalization, or surgery while participating in the program, I authorize the University of Cincinnati, through its representatives, to secure any necessary treatment. In some cases, access to medical care may be more than 24 hours away and services may be limited. If coverage is not provided through the local program provider, I understand that such treatment shall be solely at my expense, and I shall reimburse the University of Cincinnati or its representatives for any expenses that they might incur on account of my condition or treatment. In the event of any emergency abroad, the University of Cincinnati may notify my emergency contact listed on the Education Abroad Emergency Information form.

I certify that all responses made on this form are complete, true and accurate, and I understand that if there are any changes in my health status, I will complete and submit an updated Student Health/Emergency Treatment Authorization. I understand that if I withhold information on this form I could be withdrawn from the program. If I am sent home for reasons related to withheld information, I will be responsible for all incurred costs. I understand that participation in this study abroad program is contingent on receipt by UC International Programs of this completed and signed form.

Participant Signature: _____ Date: _____

If you have any questions regarding medical problems, immunization requirements, or other health issues, call the University Health Services at least 45 days prior to departure.

Travel health appointments are offered to students of the University of Cincinnati who have Student Health Insurance only. Appointments are made at least 1 month prior to departure in order for immunizations to take full effect. Payment for immunizations is due at the time of service and is not covered by Student Health Insurance.

To make an appointment call:
East Campus, Holmes Building, 1st floor 513-584-4457
West Campus, Lindner Athletic Center, 3rd floor 513-556-2564

Please leave this copy in booklet.