## STATE UNIVERSITY OF NEW YORK Overseas Academic Programs

Last

Name: \_\_

## STUDENT HEALTH INFORMATION

Please type or print in ink.		
First	Middle	Potsdam ID

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Program:			SUNY Potsdam
	Location Abroad	Approximate dates of the program	Administering SUNY

RETURN TO SUNY POTSDAM, INTERNATIONAL EDUCATION & PROGRAMS, CRUMB LIBRARY 107, 44 PIERREPONT AVENUE, POTSDAM, NY 13676 or by email attachment to <a href="mailto:international@potsdam.edu">international@potsdam.edu</a> or by fax 315-267-2811.

**To the Student:** The information provided will remain confidential. Be aware that you will be responsible for your own care, though SUNY and the organization hosting you overseas will try to provide assistance. Please be honest with yourself and prepare accordingly. The questions that follow will help guide you in preparing for your stay abroad. Indicating that you have health concerns may allow us to assist you in determining if you are prepared to go and can receive appropriate treatment.

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1.	Do you have or have you had any physical, psychological or emotional conditions (including eating disorders), that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? If yes, explain below and plan to see your health care provider to discuss your care.	□ Yes*	□No
2.	Have you arranged to receive all the necessary immunizations and medications recommended for visiting the program site by reviewing information that:  - may have been provided by SUNY;  - may have been provided by the program site;  - is available on the US Center for Disease Control and Prevention website; and  - may be available from the government of the countries you will enter?	□ Yes	□ No*
3.	Do you have any allergies, reactions to medications, or dietary restrictions? If yes, consider what you may need to manage your condition or restrictions. If needed, see your health care provider for assistance in planning for your care. You may list any allergies or dietary restrictions below so we can inform overseas providers. However, SUNY can only inform and cannot ensure that you can be protected from exposure.	□Yes	□No
4.	Are you currently taking or have you recently discontinued any medications you may need while abroad? If yes, list medication name and purpose.  Please consider how you will have access to the medication you need and consult with your physician to develop a plan for managing your condition while abroad. Depending on the medication, SUNY may request additional information.	□ Yes*	□No
5.	(Disclosure of disabilities is optional) Do you have a disability for which you are seeking accommodations? If yes, provide a description of desired accommodations. Please be aware that the Americans with Disabilities Act (ADA) does not apply outside the borders of the United States. The Administering Campus will assist you, to the extent possible, to obtain the accommodations you may want; however, it may not be able to obtain the accommodations necessary to enable you to participate in all aspects of the overseas program.	□ Yes	□No

6. Person to notify in case of emergency, illness	or accident:		
Name:	Relationship to stud	dent:	
Street/Apt #:	Daytime Telephone	e #: ()	
City, State, ZIP:	Evening Telephone #	#: ()	_
E-mail Address:	Cell Telephone #:	()	_
Second person in the event that the above of	annot be reached:		
Name:	Relationship to stud	dent:	
Street/Apt #:	Daytime Telephone	e #: ()	
City, State, ZIP:	Evening Telephone #	#: ()	_
E-mail Address:	Cell Telephone #:	()	_
I grant the State University of New York, its econcerning my health condition with program rephysician, psychologist or counselor who treated unable to give oral or written consent, I grant punder the supervision of a qualified physician, ir own expense. I appoint the representative of SU necessary medical, dental or surgical care, hospital certify that all responses made on this form hereafter of any relevant changes in my health to Student's Signature	presentatives, my family, in me during the past five year ermission for hospitalization administering anest INY in the host country for alization or medical evacuation are true and accurate, and	nsurance company representate rs or is now treating me. In situan and treatment recommende thetics and performing necession the program to act on my behion for me should this be required that I will notify the Admin	ives and with any ations where I am d and carried out ary surgery at my half in authorizing red.
Parent/Guardian's Signature (required if student	is under 18 years of age)	Date	
*If you answered yes to 1, or 4, or no to review your medical history and travel plans To the Treating Clinician: Please review the studplans and sign below. A physical exam is not required.	s and have him/her sign b dent's medical history, disc	below. cuss with him/her the upcomin	ng overseas study
I have reviewed this student's medical history and medications that may be required, and develope overseas program, if needed. (Attach pages as ne	ed a treatment plan for the		
Signature of Provider	Printed Name of Pr	- rovider	
Address and Phone Number of Provider			

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