OFFICE OF INTERNATIONAL SERVICES
UT HEALTH SCIENCE CENTER®
SAN ANTONIO

EDUCATION ABROAD PROGRAM
MEDICAL SELF-ASSESSMENT AND TREATMENT DISCLOSURE & RELEASE FORM

Name of Education Abroad Participant: _____

Student Number: _____

Education Abroad Program Name/Location: _____

Education Abroad Program Dates: _____

It is vital for the University to have your current health information on file in case of an emergency abroad. Please provide any changes in your health situation to the Faculty Advisor prior to and during participation in the program, including changes in any prescription medications you may be taking. **This information is not used to affect your eligibility to participate in the Program, but will help to facilitate any necessary accommodations for your participation. All information provided is private and confidential and will be reviewed only by University personnel involved in delivery of the Program or its agents and who have legitimate educational or safety need to know about your health history.**

Please answer the following health questions completely and to the best of your knowledge. **If you answer yes to any of the questions, please supply details.**

1. Are you currently receiving, or have you received in the past two years, counseling for the treatment of any emotional problem, drug addiction, alcoholism, psychiatric condition or eating disorder? ☐**Yes** ☐**No**

IF YES _____

_____

2. Do you have any significant chronic medical conditions requiring on- going medical supervision and treatment, or have you had in the past any significant condition which is currently in remission (Ex. Diabetes, heart problem, pregnancy, cancer, etc.)? ☐**Yes** ☐**No**

IF YES _____

_____

3. Do you have any allergies (to medication, food, insects, etc.)? ☐**Yes** ☐**No**

IF YES _____

_____

4. Will you need a continuation of medical treatment while you are participating in this education abroad program? ☐**Yes*** ☐**No**

IF YES _____

_____

**If yes, you must bring an adequate supply of medications for the duration of the program. It is very important that you have a valid, physician-issued prescription for the medication with you at the time.*

5. Will you need a continuation of medical treatment while you are participating in this education abroad program? ☐**Yes** ☐**No**

IF YES _____

_____

6. Will you require assistance for any physical disabilities while you are participating in this education abroad program? ☐**Yes** ☐**No**

IF YES_____

_____

7. Is there any additional information (concerning medical or mental health conditions or physical disabilities) that would be helpful for the program to be aware of during your education abroad experience? ☐**Yes** ☐**No**

IF YES_____

_____

MEDICAL TREATMENT ABROAD DISCLOSURE STATEMENT:

➢ **I understand that it is my obligation to seek consultation from my doctor if I have any medical condition or need that may affect my ability to safely participate in this Program.**

➢ Having been accepted to participate in an education abroad program organized and/or sponsored by the University of Texas Health Science Center at San Antonio, I hereby authorize the Faculty Advisor of my Program to sign as my authorized agent all documents related necessary medical care (including surgery). For the purpose of this document, this means hospital admission consent/ permission documents and any and all other documents related to health care, interventional or surgical processes, and/or a treatment plan will be facilitated by the Faculty Advisor in the event of any emergency via which I am or might become incapacitated. The Faculty Advisor will assist me to the best of his/ her ability if my medical situation prevents my direct participation in the decision- making process related to my immediate health situation.

➢ I also give permission for the person(s) listed on the Emergency Contacts Form to be contacted in the case of a medical emergency.

➢ I further acknowledge and agree that I will be solely responsible for all financial obligations arising from any health care that I may receive as a result of this authorization.

Signature of Participant_____ Date_____