



PARTICIPANT HEALTH/EMERGENCY TREATMENT AUTHORIZATION

Center for Global Education – Administration Bldg Rm. 126 – University Hts, OH 44118

The medical review of this form and admission into a program are independent of each other. The purpose of this form is to help the Center for Global Education provide appropriate assistance to you should the need arise during your study abroad experience.

It is important that we be aware of any medical problems (past or current), including mental health conditions, which might affect your ability to participate in a JCU study abroad program. This information will be kept confidential in accordance with the law. Any disclosure of such information will be made only to appropriate individuals, and handled with the highest level of discretion in order to protect your privacy. Relevant information will be shared with program staff, leaders, or appropriate professionals as it relates to your health and safety. Failure to disclose significant health issues may result in dismissal from the program.

Health tests or immunizations may be required prior to departure in certain circumstances.

Name: _____ Passport #: _____
Last First

Sex: ☐ F ☐ M Date of birth: ____/____/____ Citizenship: _____
Month/Date/Year

E-mail address: _____

Current address: _____
Street address City State Zip

Local phone: _____ Cell phone: _____ Work phone: _____

Country/countries of program: _____ Date and year of program: _____

This information is required to coordinate treatment in the event of a medical emergency.

ALLERGIES (If not applicable, please indicate by writing N/A)

<u>Medication allergy:</u>	<u>Reaction:</u>	<u>Treatment, if exposed:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Food or environmental allergy:</u> <small>(Foods, dust, chemicals, household items, pollen, bee stings, etc.)</small>	<u>Reaction:</u>	<u>Treatment, if exposed:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any dietary restrictions or concerns, eg. vegetarian or diabetic? If so, please list them below: _____

MEDICATIONS (If not applicable, please indicate by writing N/A)

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 "Health Care" in the Study Abroad Pre-Departure Handbook for information regarding transportation and use of your medication abroad.)

<u>Name of Medication:</u>	<u>How often taken:</u>	<u>For what condition?</u>	<u>Length of time treated (approx.)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: Participants must bring an adequate supply of medications that are required on a daily or routine basis, in their original bottles, when traveling abroad. We suggest you bring a copy of all prescriptions while traveling.

DISABILITIES (If not applicable, please be sure to check NO)

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

☐ Yes (If yes please discuss with program leader 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 accommodation in a timely manner, JCU may not be able to assess and accommodate your needs.)

☐ No

Are you a program leader?

☐ Yes, If yes, please contact Human Resources.

☐ 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, mental illness, phobias etc.) that may need special consideration before or during your experience or may affect your participation in this program?

☐ Yes (If yes, you are advised to consult with your health care provider. Please supply an explanation below)

☐ No

Condition(s)

How often do you have symptoms?

Plan for managing this condition while abroad

HEALTH AND EMERGENCY AGREEMENT

I authorize the release of information contained in this *Participant Health/Emergency Treatment Authorization* form for access and review by appropriate health professionals in the JCU Student Health Center. I understand that if I have not turned in this form in a timely manner, there may be insufficient time for the JCU Student Health Center to review this information. If further medical information is required, I understand that I will be contacted by a health care professional in the JCU Student Health Center 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 JCU Center for Global Education Director, Assistant Director, the JCU program leader, and the host institution's resident director (if applicable).

In the event that I need emergency medical care, hospitalization, or surgery while participating in the program, I authorize John Carroll University, 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 available through the JCU Study Abroad insurance provider, I understand that such treatment shall be solely at my expense, and I shall reimburse John Carroll University or its representatives for any expenses that they might incur on account of my condition or treatment. In the event of any emergency abroad, John Carroll University may notify my emergency contacts.

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 *Participant Health/Emergency Treatment Authorization*. I understand that if I withhold information on this form I could be dismissed from the program. If I am dismissed from the program for reasons related to the withheld information, I will be responsible for all incurred costs. I understand that participation in this study abroad program is contingent on receipt by the JCU Student Health Center 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 JCU Student Health Center at 216-397-4349.

PLEASE RETURN COMPLETED FORM TO JCU STUDENT HEALTH CENTER