Office of Global Education
California State University San Marcos
San Marcos, California 92096-0001 USA

***Tel:** (760) 750-4091; **Fax:** (760) 750-3284*
tgabbard@csusm.edu
www.csusm.edu/global

MEDICAL DISCLOSURE

Program Name and Dates: _____

Participant's Name: _____ Student ID. _____

The following medical information may be necessary in the event of serious illness or accident. Please complete this form accurately and truthfully. The facts you disclose will be kept confidential and will be used only to help the staff respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness, particularly if you are unable to respond clearly to the medical staff's inquiries. Please print your responses.

PERSON TO CONTACT IN EVENT OF EMERGENCY (parents or nearest relative)

Name: _____ Relationship: _____

Phone: Home (____) _____ Work (____) _____

MEDICAL INSURANCE COVERAGE

Coverage provided by the program while in Ecuador run through www.csuhealthlink.com

Please list any additional medical insurance coverage that will apply to your travel abroad:

Name of Insurance Company_____

Policy #_____

MEDICAL SELF-ASSESSMENT

Though a study abroad experience can be exciting and rewarding, it can also be both physically and emotionally demanding. Therefore we ask that you provide a candid evaluation of your health. A certain amount of stress due to culture shock or the change in living conditions and facilities is a normal part of the study abroad experience. However, in some cases, such stress may aggravate disabilities or illnesses that you have under control at home.

With this form, we hope to create an awareness of any health issues that you should take into consideration before going abroad. This information will be used primarily to guide us in making appropriate arrangements for you as a CSUSM participant. The information will also be forwarded to the coordinator at your host institution.

Instructions: Please read each question below and answer either YES or NO by checking the appropriate box.

Do you have any pre-existing conditions? ❑Yes ❑No

If so, please explain_____

Do you currently receive any treatments or medications on a regular basis ❑Yes ❑No

Do you have any dietary restrictions? ❑Yes ❑No

If so, please explain_____

Do you have any allergies to medication, plants, food, animals, insect stings, etc.? ❑Yes ❑No

If so, please explain _____

Do you have any physical limitations or disabilities? ❑Yes ❑No

If so, please explain _____

Have you ever had a major illness? ❑Yes ❑No

Have you ever had a major surgical operation or been advised to have one? ❑Yes ❑No

Have you ever been hospitalized? ❑Yes ❑No

Have you ever received treatment for drug ❑Yes ❑No

Have you ever been treated by a psychiatrist or psychologist for any mental, emotional or nervous disorder? ❑Yes ❑No

Have you ever had treatment in a mental institution? ❑Yes ❑No

Are there any concerns regarding your health, family history or other matters that you would like to discuss with the Travel Study Coordinator? ❑Yes ❑No

If yes, please indicate a phone number and time when you may be contacted.

Daytime Phone Number (_____) _____-_____ Best time to call _____

I have completed this form to the best of my abilities and understand that any omissions may result in the cancellation of my participation in this program.

Student Signature_____ Date _____

Student Name (print)_____

Signature of Parent or Guardian if student is under 18_____ Date _____

Parent or Guardian Name (print)_____