

**Temple University
International Programs
HEALTH INFORMATION**

This form is to be completed by the participant and returned by **November 10.**

NAME _____ **BIRTH DATE** ___/___/___ **GENDER** _____

PROGRAM _____ **SEMESTER** _____

The purpose of this form is to help International Programs to be of maximum assistance to you should the need arise during your study abroad experience. Mild physical or psychological disorders can become serious under the stresses of life while studying abroad. It is important that the program is made aware of any medical or emotional problems, past or current, that might affect you in a foreign study context. The information provided will remain confidential and will be shared with the program staff, faculty, or appropriate professionals only if pertinent to your own well being. This information does not affect your admission into the program.

MEDICAL HISTORY

Yes___ No___ 1. Do you have any medical conditions (including allergies), learning disabilities, or physical disabilities that would be helpful for the program to be aware of? (If yes, please explain.)

Yes___ No___ 2. Have you ever been treated or are you currently being treated for any psychological or emotional problems that would be helpful for the program to be aware of? (If yes, please explain.)

Yes___ No___ 3. Are you taking any medications? (If yes, please list. Give brand and generic name, if known.)

Yes___ No___ 4. Have you had any major injuries, diseases or ailments in the past five years? (If yes, please explain.)

I certify that all responses made on this Health Information form are true and accurate, and I will notify the International Programs Office hereafter of any relevant changes in my health that occur prior to the start of the program.

Signature of Participant _____ Date _____

Please turn over

**Temple University
International Programs
EMERGENCY CONTACT INFORMATION**

This form is to be completed by the participant and returned **by November 10.**

The information requested below will be used only in the event of emergency and is limited to the duration of your participation in a Temple University-sponsored program. The information will be kept confidential.

YOUR NAME _____

PROGRAM _____ **SEMESTER** _____

NAME OF PARENT OR LEGAL GUARDIAN _____

ADDRESS _____

HOME PHONE (____) _____ **WORK PHONE** (____) _____

E-MAIL ADDRESS _____

EMERGENCY CONTACT ONLY IF OTHER THAN PARENT OR GUARDIAN (do not fill out this section if we should contact the parent or legal guardian indicated above in the event of an emergency):

NAME _____

ADDRESS _____

HOME PHONE (____) _____ **WORK PHONE** (____) _____

E-MAIL ADDRESS _____

RELATIONSHIP TO YOU _____

PHYSICIAN CONTACT:

NAME _____ **PHONE** (____) _____

ADDRESS _____

If there are other physicians you feel we might need to contact, please supply their contact information on an additional sheet of paper.

I authorize Temple University to release education records and other information relating to me to my parent, legal guardian or emergency contact in any situation that involves health or safety issues.

Signature of Participant _____ **Date** _____