

**Medical Self Assessment Form**

Name of Applicant \_\_\_\_\_

Study Abroad Program \_\_\_\_\_ Program Dates \_\_\_\_\_

Because an exchange experience can be both physically and emotionally demanding, 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 exchange experience. However, in some cases, such stress may aggravate disabilities or an illness which 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 USC study abroad participant. The information will also be forwarded to the exchange program coordinator. Any information you provide will be handled in a confidential manner.

**Instructions:** Please read each question below and answer by selecting either YES or NO. If you answer YES, please provide additional information in the space provided on the second page.

- |                                                                                                                                            |      |    |
|--------------------------------------------------------------------------------------------------------------------------------------------|------|----|
| Do you have any pre-existing medical conditions?                                                                                           | Yes  | No |
| Do you currently receive any medical or psychological treatment or medications on a regular basis?                                         | Yes  | No |
| Have you ever been treated by a psychiatrist, psychoanalyst, or psychologist for any mental, emotional or nervous disorder?                | Yes  | No |
| Do you plan to continue, resume or begin care for these concerns while abroad?                                                             | Yes  | No |
| Do you have any dietary restrictions?                                                                                                      | Yes  | No |
| Are you allergic to any medications, plants foods, animals, insect stings, etc?                                                            | Yes  | No |
| Do you have any physical limitations or disabilities?                                                                                      | Yes  | No |
| 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 treated in a hospital?                                                                                                  | Yes  | No |
| Are there any concerns regarding your health, family history, or other matters that you would like to discuss with a study abroad advisor? | Yes* | No |

\*If yes, please indicate your phone number and time when you may be contacted.

Primary phone number \_\_\_\_\_ Best time to call \_\_\_\_\_

continued

## Medical Self Assessment Form

If you answered Yes to any of the questions above, please provide additional explanation:

*By signing below, I certify that the above information is true to the best of my knowledge. I also acknowledge the following:*

\_\_\_\_\_ *I and my parents or guardians, agree to release and hold harmless the University of South Carolina and their employees and agents from any claims arising out of the provision of medical care in my host country.*

\_\_\_\_\_ *I understand and agree that this form will be released to my host institution or program provider. I also understand and agree that the University of South Carolina is not responsible for any decisions which that institution/program provider may make based upon information it received from any source about my physical condition.*

\_\_\_\_\_ *I have taken the steps necessary to confirm that I will have adequate medical insurance coverage while abroad.*

*If my parents or guardians have not signed this form, I represent and certify that I am not a minor.*

---

Signature of Applicant

Date

---

Signature of Parent or Guardian

Date

Emergency Contact: \_\_\_\_\_ Relationship to You: \_\_\_\_\_

Contact's Address (street, city, state, zip): \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Evening phone: \_\_\_\_\_ Email \_\_\_\_\_

**I give International Programs permission to communicate with my emergency contact person regarding all issues surrounding my study abroad program.**    Yes    No