

**UNIVERSITY OF NOTRE DAME  
INTERNATIONAL STUDY PROGRAMS**

**HEALTH QUESTIONNAIRE**

**Section A:** To be completed by student. Sections A & B should be given to a physician who has seen student within the past year. Physician will complete Section B and return entire Health Questionnaire to ISP office with a blank copy of his/her office letterhead or a business card.

Student's Name: \_\_\_\_\_

Student's Notre Dame I.D.#: \_\_\_\_\_

Name/location of study abroad program:  
\_\_\_\_\_

Length of Program (check one):

Academic Year \_\_\_\_\_ Fall Semester Only \_\_\_\_\_ Spring Semester Only \_\_\_\_\_

Congratulations on your recent acceptance for participation in an international study program. In order to allow the Notre Dame International Study Programs Office to provide appropriate assistance to you during your study abroad experience, it is important that we be aware of any medical or emotional conditions, past or current, which might influence your ability to live, study or travel abroad for an extended period of time. This information will be kept confidential as provided herein by the University and the host institution, if any, for your program. It will not be used to prevent you from participating in the program unless your physician or another health care provider deems you unfit to participate, or unless your participation would require the University to fundamentally alter an academic program or take unreasonable steps to accommodate your condition. It is intended to ensure that your needs are being attended to and met to create a positive and healthy experience.

1. Have you had any serious illnesses, injuries or medical conditions within the **past year** for which you have received or are presently receiving professional medical treatment?

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you ever been or are you currently in treatment for a mental, emotional, or psychological condition?

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Do you have any physical or mental impairment or condition which may require special facilities or assistance while abroad? (If appropriate, please attach a memo from the Office of Disabilities or University Counseling Center indicating the condition and your needs.)

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you suffer from any allergies (e.g., food, medicine, insects, etc.)?

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

5. Do you have any dietary restrictions or special dietary needs?

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

6. Do you have any eating concerns or have you ever sought help for eating issues?

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

7. Are you experiencing anything unusual lately (e.g. distressing thoughts or feelings, bad dreams, too much or too little energy, grief over a loss, high levels of stress or anxiety, etc.)?

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

8. Are you currently taking any medications for medical or psychological purposes?

No: \_\_\_\_\_

Yes: \_\_\_\_\_

If yes, please describe conditions and requirements: \_\_\_\_\_  
\_\_\_\_\_

8. Immunizations received in the last 90 days: \_\_\_\_\_  
\_\_\_\_\_

**PERMISSION FOR EMERGENCY TREATMENT:** I hereby grant permission for designated representatives of the University of Notre Dame and/or the host institution, if any, to consent on my behalf to the provision of emergency medical care, including but not limited to the examination, diagnosis and treatment of any emergency condition or injury I may sustain or experience during the program. This consent shall include but not be limited to emergency blood transfusions, surgical procedures, the administration of anesthesia and other medical tests and procedures recommended by on-site medical authorities. All such treatment shall be at my expense, and I agree to reimburse the University or its representatives for any expenses which they or any of them might incur on account of my condition or treatment.

**PERMISSION TO SHARE INFORMATION:** I hereby give the Director of the International Study Programs office of the University of Notre Dame (and his/her designee) and representatives of the host institution, if any, permission to communicate, as necessary, with one another, and/or with my parents, university officials, immediate family members, emergency contact person(s), doctor(s) and/or health care professionals regarding issues concerning my study abroad experience. This may include but is not limited to information about my health and safety, student conduct or disciplinary matters, academic issues, student account information and/or any other relevant conduct or circumstance before or during the Program experience.

**HEALTH AGREEMENT:** I certify that I do not have any condition which would prevent me from being able to satisfy the fundamental requirements of this international program. I authorize release of this information for access and review by the Director of the International Study Programs office of the University of Notre Dame (and his/her designees) and appropriate university and health or counseling professionals affiliated with the University of Notre Dame. I give these individuals and my physicians and/or health care professionals permission to communicate my health condition with each other and with any physician, psychologist, or counselor who treated me during the past four years. I understand that if this information is pertinent to my well being abroad, it may be communicated to the Director of the University's International Study Programs office (and his/her designee) and appropriate University and host institution representatives.

I certify that all responses made on this form are true, complete and accurate, and I agree to notify the Director of the International Study Programs office of the University of Notre Dame of any relevant changes, including a change in the state of my health, at any time prior to the end of the program. I understand that the completion and submission of this entire form is required in order for me to participate in the international program referenced above. I further understand that providing false information (or failing to provide truthful responsive information) on this form may result in University disciplinary action against me, including but not limited to revocation or early termination of my participation in the above-referenced international program at any time.

Student's Signature: \_\_\_\_\_

Student's Name: \_\_\_\_\_  
(Printed)

Dated: \_\_\_\_\_

**Section B (To be completed by a physician who has seen student within the past year and returned to ISP together with Section A.)**

***A NOTE TO THE DOCTOR: Please attach a blank copy of your office letterhead or a business card and return the "Health Questionnaire" via fax or mail, as soon as possible, to the International Study Programs office at the University of Notre Dame, 152 Hurley Bldg, Notre Dame, IN 46556. Telephone: (574) 631-5882 Fax: (574) 631-5711***

The above-named student has been selected to participate in an international study abroad program. Depending upon the program, students spend from a semester to a full year studying, living and traveling abroad. Living and studying in a foreign environment often creates unexpected emotional and physical stress which can exacerbate otherwise mild conditions. It is important that all participants be able to adjust to dramatic changes in their living environment, climate, diet, living conditions and studying conditions that may disrupt accustomed patterns of behavior. Your complete and candid evaluation of the student's health is, therefore, extremely important to the ISP office Director in anticipating and working with the student to appropriately address any problems that might arise during the student's international study abroad experience.

**PHYSICIAN'S RECOMMENDATION:**

Based upon the information given by the student on this Health Questionnaire form and pursuant to my review of the student's personal health history, as well as my recent physical examination of the student and his/her medical records on file in this office, I find that this student is fit to participate in the proposed program of living, studying and traveling in the foreign country referenced above.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Name (printed)