Hofstra University
Study Abroad Programs
Medical Information Form

This form is to be completed by the participant. The purpose of this form is to enable Hofstra University to provide appropriate assistance to you should the need arise during your study abroad experience. It is important that we be aware of any medical or emotional problems, past or current, which might affect your ability to participate in the study abroad program. Please be honest and comprehensive. The information provided will remain confidential as allowed by law and will not be used to disqualify you from the program. Relevant information will be shared with program staff, faculty, or appropriate professionals as it relates to your health and safety.
Hofstra University shall not be responsible for participant's failure to provide complete and accurate information.

Student's Name:_____ Hofstra ID#:_____

Sex: □ F □ M Date of Birth:_____ Citizenship:_____

Current Address:_____

Phone:_____

Name of Study Abroad Program:_____

Country/Countries of Program:_____ Dates of Program:_____

This information is required to coordinate treatment in the event of a medical emergency. If you answer YES to any of the following questions, please provide details of the condition and the treatment you received or are continuing to receive. Please contact us if any conditions or treatments change before the start of your program.

Are you currently under medical treatment? If yes, explain.

_____
_____
_____
_____

Are there any medical conditions that we should be made aware of? If yes, explain.

_____
_____
_____
_____

Do you suffer from any allergies? If yes, explain.

_____
_____

_____
_____

Are you currently taking any medications? If so, specify.

_____
_____
_____
_____

Do you have a disability that will require accommodations while abroad? If so, explain.

_____
_____
_____
_____

Are you allergic to any medication? If yes, explain.

_____
_____
_____
_____

Do you suffer from any food allergies or have any dietary restrictions? If so, explain.

_____
_____
_____
_____

Additional Health Conditions

Do you have any additional health conditions other than those previously listed (such as surgeries, hospitalizations, injuries, chronic conditions, physical illness, psychological illness, emotional illness, mental illness, etc.) that may need special consideration before or during your experience or may affect your ability to participate in this program?

□ yes □ no

If yes, you are advised to consult with your health care provider. Please provide an explanation below:

_____
_____
_____
_____

Physician Information

Physician's Name:_____
Physician's Address:_____
_____
Physician's Phone:_____

Authorization Statement

I hereby authorize the release of information from my medical history upon the request of Hofstra University's Study Abroad Programs. I further authorize the release of information by the Study Abroad Program to its affiliated institutions. I certify that the information on this Medical Information Form is true an correct, and I will notify Hofstra University's Study Abroad Program hereafter of any relevant changes in my health that occur prior to the start of the program. I understand that this information will be used only for the purposes for which it was prepared.

Student Name:_____

Signature:_____
(or if under 21 Parent/Guardian Signature)

Date:_____