

Loyola Study Abroad: Health Self Evaluation

Name: _____ Study Abroad Program: _____
 Term: _____

TO BE COMPLETED BY THE STUDENT: Please complete and sign this form.

Gender: M ___ F ___

Do you hold religious beliefs that might impact the provision of emergency medical treatment while you are abroad?

YES ___ NO ___ If yes, give details _____

Are you required to wear a health emergency bracelet? YES ___ NO ___

If yes, for what condition? _____

Have you had or do you currently have any of the following conditions? Please mark all that apply, specifying the date, whether past or current. If yes, please detail information. Attach additional sheets if necessary.

Medical Condition	Past Date	Current	If yes, please detail information and any treatment which may be needed while you are abroad.
1. Alcohol/Drug addiction	_____	_____	_____
2. Allergies	_____	_____	_____
3. Asthma	_____	_____	_____
4. Cancer	_____	_____	_____
5. Chronic Condition	_____	_____	_____
6. Diabetes	_____	_____	_____
7. Eating Disorder	_____	_____	_____
8. Epilepsy/Seizure Disorder	_____	_____	_____
9. Frequent Trouble Sleeping	_____	_____	_____
10. Heart Disease	_____	_____	_____
11. Hypoglycemia	_____	_____	_____
12. Painful shoulder, knee or back	_____	_____	_____
13. Thyroid Condition	_____	_____	_____
14. Other: _____	_____	_____	_____

Have you had any injuries, which have required hospital/ER attention? (i.e.: major accident, etc.) YES ___ NO ___

If yes, **when** and for **what**? _____

Have you ever been hospitalized? YES ___ NO ___ If yes, **when** and for **what**? _____

Have you had any surgical procedures? YES ___ NO ___ If yes, **when** and for **what**? _____

What is your condition as a result of the surgery? _____

Are you currently taking any medications? YES ___ NO ___ If yes, **which medications** and for **what**? _____

Have you ever been treated for any psychological/emotional problems? YES ___ NO ___ If yes, **list dates**: _____

If yes, please describe the nature of the problem: _____

Did your treatment require medication? YES ___ NO ___ If yes, please **list medications**: _____

Current Status: _____

If you require accommodations -academic or otherwise- for your study abroad program, please contact Services for Student's with Disabilities (SSWD) at Loyola University Chicago. Contact information: (Ph) 773-508-7714; (Fax) 773-508-3810.

In signing this document, I verify that all of the medical and psychological information I have provided is accurate and complete, and I will notify Loyola hereafter of any relevant changes in my health that occur prior to the start of the program.

Student Signature _____ **Date** _____

Please Fill Out Emergency Contact Information (See Reverse Side of Form)

List two emergency contacts for while you are abroad:

1) Contact's Name: _____

Relationship to You: _____

Contact's Phone Number: _____

Address: _____

Email: _____

2) Contact's Name: _____

Relationship to You: _____

Contact's Phone Number: _____

Address: _____

Email: _____