

## 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: \_\_\_\_\_