**Rider University** **Health Disclosure Information**
**Overseas Academic Programs**

Name: _____
Last First Middle
Program: _____
Location Abroad Length of Overseas Program Dates of Participation

**TO THE STUDENT**: Complete this form and review it with your MD, nurse practitioner (NP), or physician assistant (PA) during your physical examination. The information provided by you and your physician will remain confidential.

1. Are you generally in good physical condition? (If no, explain) ___ Yes ___ No

2. Have you ever been, or are you currently being treated for any psychological or emotional problems? (If yes, have your physician or counselor attach a note of explanation) ___ Yes ___ No

3. Do you have any other on-going emotional or physical conditions (including eating disorders) that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? (If yes, list and indicate recommended treatment). ___ Yes ___ No

4. Do you have any allergies, reactions to medications and/or dietary restrictions? (If yes, explain) ___ Yes ___ No

5. Are you currently taking any medications? (If yes, list medication name and ailment). ___ Yes ___ No

6. Have you had any major injuries, diseases, surgical procedures or ailments/illnesses in the last five years?

___Yes ___ No

7. (Disclosure of disabilities is optional). Do you have a disability for which you are seeking accommodations? If yes, please provide a description of desired accommodations. Please be aware that the Americans with Disabilities Act (ADA) does not apply outside the borders of the U.S. However, the Administering Campus will assist you, to the extent possible, to obtain the accommodations you may want. We may not be able to obtain the accommodations necessary to enable you to participate in all aspects of the overseas program.

___Yes ___ No

I certify that all responses made on this form are true and accurate, and that I will notify the Administering Campus hereafter of any relevant changes in my health that occur prior to the start of the program.

Student's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____
(Required **IF** student is under 18 years of age)

*-Continued on following page-*

I understand that, under the Family Educational Rights and Privacy Act, the information I set forth on this form may be disclosed to Rider University personnel who have a legitimate educational interest in the information, and in the event of a health or safety emergency. The University believes that this may include, but is not necessarily limited to, Rider University Center for International Education administrators and staff at home and abroad, and personnel of the Rider University Office of Public Safety, the Rider University Student Health Center and the Rider University Student Success Center.

**I certify that the information above is true and correct to the very best of my knowledge. I acknowledge that, ultimately, I am responsible for my well-being and that accurate information here is an important part of fulfilling my responsibilities. In addition, I am aware that in a medical emergency my parent(s)/guardian(s) and/or emergency contact(s) will be notified.**

_____ _____ _____

Parent/Guardian Signature Relationship Date

_____ _____

Participant Signature Date

**PARENTAL CONSENT FOR MEDICAL CARE OF PARTICIPANT UNDER THE AGE OF 18**