



# Office of Global Studies

## HEALTH DISCLOSURE FORM

Name \_\_\_\_\_ X Number: \_\_\_\_\_  
Program: \_\_\_\_\_ Cell Tel: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Home Tel: \_\_\_\_\_

It is essential that the Office of Global Studies is aware of any health conditions, past or present, that you have. We will keep this information confidential and only share it with program administrators and medical professionals as needed for incidents directly related to your well-being. Please be aware that these forms are sent directly to the Office of Global Studies and thereby are not part of your University medical file. Therefore it is imperative that you provide us with as complete health information as possible.

NOTE: If you are currently under treatment for a medical/mental health condition, speak with your treating medical/mental health professional regarding your time away from campus, making sure to arrange for services prior to departure — including any required medication.

**Please complete the following questions to the best of your knowledge.**

<p><b>Are you currently being treated, or have you been treated within the past two years, for a physical health condition, injury or disease? If "yes," please explain and include any ongoing treatment.</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>Are you currently being treated, or have you been treated within the past two years, for a mental health condition (e.g., depression, addiction, eating disorder)? If "yes," please explain and include any ongoing treatment.</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>Do you have any allergies (e.g., to medication, food, insects)? If "yes," please list and explain how you intend to manage your condition while away from campus.</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

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<p><b>Are you currently taking any prescription medications? If "yes," please list and indicate what condition for which this medication is being taken.</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>Have you had any operations in the past two years? If "yes," please list the type and date of the operation.</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>Do you have a physical, learning or other disability of which the University should be aware in order to help you achieve your educational goals? If "yes," please describe.</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>Do you have any dietary restrictions? If "yes," please describe.</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>



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<b>Is there any additional information that would be helpful for the program to be aware of during your experience away? If yes, please describe.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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**Please attach additional pages or supporting documentation as needed.**

I certify that all responses made on these forms are true and accurate, and that I will notify the Office of Global Studies hereafter of any relevant changes in my health that occur prior to the start of the Program.

I understand and agree that, based upon the information provided in this Health Disclosure Form, I may be required to submit additional documentation.

If I am under treatment for any medical or mental health condition, I further certify that I have sought the advice of a medical/mental health professional regarding my condition and, prior to departure, have made/will make arrangements for appropriate medical/mental health services during my time away, as directed by my medical/mental health professional.

I hereby authorize the Office of Global Studies to grant access to this Health Disclosure Form to (i) its counterpart offices, or, if applicable, the faculty member(s) or administrator(s) leading St. John's programs (ii) Student Health Services, and (iii) the Counseling Center, and I further authorize representatives of the Office of Global Studies and/or its counterpart offices or the faculty member(s) or administrator(s) leading St. John's programs to disclose these materials to licensed health care providers in the event I need medical treatment.

I understand that in order to revoke this authorization I must do so in writing and that such revocation shall not apply to records to which access has been granted or which have been released to third parties prior to the date of revocation.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date: