TEXAS STATE
CONTINUING EDUCATION

Health Information

This form is to be completed by the participant or parent/guardian

Name_____
DOB___/___/_____ GENDER__Woman__Man__Nonbinary__Other__Prefer Not to Answer

Program_____

The purpose of this form is to help Texas State to be of maximum assistance during your extension studies experience. Mild physical or psychological disorders can become exacerbated with the stresses of life while studying elsewhere. It is important that the program be made aware of any medical or emotional problems you have experienced. The information provided will remain confidential and will be shared with program staff, faculty, or appropriate professionals only if necessary to your wellbeing. Texas State may not be able to accommodate all individual needs or circumstances. <u>This information does not affect your admission into the program.</u>

Yes___ No___ 1. Are you generally in good physical condition? (If no, please explain)

Yes___ No___ 2. Have you ever been treated or are you currently being treated for any psychological or emotional conditions? (If yes, please attach explanation.)

Yes___ No___ 3. Do you have any allergies, including food allergies? (If yes, please attach explanation.)

Yes___ No___ 4. Are you taking any medications? (If yes, please attach explanation.)

Yes___ No___ 5. Have you had major injuries, diseases, or ailments in the past five years that may affect your full participation in this Study in America program? (If yes, please attach explanation.)

Yes___ No___ 6. Are you a vegetarian or are you on a restricted diet? (If yes, please attach explanation.)

Yes___ No___ 7. Is there any additional information (concerning medical conditions or physical disabilities) that would be helpful for the program to be aware of during your Study in America experience? (If yes, please attach explanation.)

Name and telephone number of physician: _____

I certify that all responses made on this Health Information form are true and accurate, and I will notify the Texas State Office of Distance and Extended Learning hereafter of any relevant changes in my health that occur prior to the start of the program.

Signature of participant: _____ Date: _____

Parent/Guardian's signature (if student is under 18): _____ Date: _____

In the event of an emergency, illness or injury affecting (my son, my daughter, my ward, or myself), _____(student's name), born_____(date), the undersigned hereby authorizes immediate hospitalization and treatment recommended by and carried out under the supervision of a qualified physician, including administering anesthetic and performing necessary surgery.

Known allergies to medication: _____

Student's blood type, if known: _____

Signature of participant: _____ Date: _____

Parent/Guardian's signature (if student is under 18): _____ Date: _____

Additional Comments

Provide additional comments / explanation below if necessary: