## Wake Forest University Health Questionnaire for Participation in Study Abroad Programs

Full Name			Age	Sex	
Last	First	Middle			
Social Security		Birth Date	Marital St	Marital Status	
Home Address			Telephone(	)	
Name and Relationship Address of next of kin		kin			
Telephone of next of kin					
receptione of next of kin	.()				
Name, address, telephor	e of Famil	y Physician			
HEALTH INSURANCE Will your current health in Yes *If your current health insust purchase health in repatriation coverage is re	nsurance polisurance polisurance specommende	olicy cover you in theNo* icy does not provide ecifically for that p	country to which you a coverage while you are	abroad, you	
	at the attent, including major ill person, and lgment of the treatmet or she may is sought. Without prioritl be made agree that it formation materials.	nding physician or vig operations and/or lnesses or injuries of without obtaining the physician or designate may evaluate the case of a more notification of the to notify the parent needed immunization ay be released to or	without prior notifications consent of the undersignee it is necessary for I further agree that the lation and treat all other infor (under 18 years a undersigned parent or guardian in the even may be administered by other health care prior consent of the lations.	of necessary ation of the gned or any health care he attending er injuries or of age) this or guardian at of such an ed. I further	
Signature of program pa	articipant_		Date		
Signature of minor's (un Date					

(continued)

## PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers under remarks.

Yes

HAVE YOU HAD

Date:\_

Yes

HAVE YOU HAD?

Allergy to:	Surgery or serious injury
Penicillin	Chronic medical condition - specify
Sulfonamides	Vision, corrective lens
Peanuts	Cancer
Bees, wasps	Heart disease
Other	Serious head injury
Specify:	Hepatitis B
•	Hepatitis C
	Kidney disease
Infectious mononucleosis	Neurological disorder
Tropical disease - specify	Depression/anxiety
Chicken pox/Varicella	Other psychological problem
Respiratory disorders including	Seizure disorder
asthma	
High blood pressure	Organ loss
Diabetes, thyroid, endocrine	
problems	
Stomach or intestinal disorders	
Blood disorders including anemia	
Headaches/migraines	
Menstrual cycle disorders	
Current prescription medicines – list	Current non-prescription medicines -
	list
Current vitamins or supplements - list	
REMARKS OR ADDITIONAL	
INFORMATION:	
And the second s	of activities 2
Are you capable of participation in a full program Is there anything additional about your health that	n of activities?YesNo at we should know? Yes No
Are you now under treatment with medication for	at we should know?YesNo
	rany medical or emotional condition?
YesNo If "yes", please explain	
ii yes , piease explairi	
Do you have a disability that may require an aca	demic or another type of accommodation to enable
	No
If we nlease contact Van D. Westervelt PhD or	NO r Michael Shuman, MEd at the Learning Assistance
	ston-Salem, NC 27109, (336) 758-5929, to make

Student, Parent or Guardian

your accommodation request.

Signed:\_