A program of study abroad can be physically, mentally, and emotionally demanding. Health care in other countries differs from health care in the United States. To ensure your safety, Mercer County Community College requires that you complete this “Health Disclosure Form”. In addition, you will need a Physician to review this “Health Disclosure Form” and complete the “Physician’s Release Form”. Both forms must be completed and submitted with your final payment in order for you to travel abroad. You will not be allowed to travel abroad without completing these 2 forms.

Please answer the following:

1. Are you under a physician’s care for a medical condition? ______yes ______no
   If yes, please explain (condition, treatment).  
   Continue on reverse side if necessary.
   __________________________________________________________

2. Are you receiving treatment or counseling for any psychological condition? ______yes ______no
   If yes, please explain (condition, treatment).  
   Continue on reverse side if necessary.
   __________________________________________________________

3. Are you taking any prescription medications, excluding birth control pills? ______yes ______no
   If yes, please explain (condition, treatment).  
   Continue on reverse side if necessary.
   __________________________________________________________

4. Do you have any drug or food sensitivities or allergies? ______yes ______no
   If yes, please explain (condition, treatment).  
   Continue on reverse side if necessary.
   __________________________________________________________

5. Do you have any physical limitations that can affect your participation in any part of this travel experience? ______yes ______no
   If yes, please explain (condition, treatment).  
   Continue on reverse side if necessary.
   __________________________________________________________
HEALTH DISCLOSURE FORM (cont.)

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.

Participant: ____________________________  __________________________
(Sign)  (Date)

Witness: ________________________________  __________________________
(Sign)  (Date)

Notice of Privacy Practices

I consent to Mercer County Community College’s use and disclosure of my personal health information to any health care provider involved in my care or to whom I may be transferred or referred for care and to family members or others who may be involved in my care.

My signature below means I was given a copy of the Notice of Privacy Practices, which explains in more detail some of the uses and disclosures of my health information. Also, my signature means I have read, understand and agree to the Notice of Privacy Practices and my questions have been answered.

Participant: ____________________________  __________________________
(Sign)  (Date)

Witness: ________________________________  __________________________
(Sign)  (Date)