Mercer County Community College
Faculty-led Study Abroad
HEALTH DISCLOSURE FORM

Study Abroad
Mercer County Community College

Name: _____ _____
(Print) (Student ID)

A program of study abroad can be physically, mentally, and emotionally demanding. To ensure your safety, complete this "Health Disclosure Form" and have it reviewed by a physician.

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.*
   _____
   _____

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)

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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)