

**KETTERING UNIVERSITY**  
International/Study Abroad Office

**HEALTH STATEMENT**

It is vital for Kettering University to have your current health information in case of an emergency. Please inform our office of any changes in your health prior to and during participation in the program, including any prescription medications you may be taking. This information is not used to affect your eligibility to participate in the program, but will help to facilitate any necessary accommodations for your participation.

Please answer the following health questions completely and to the best of your knowledge. If you answer yes to any of the questions, please supply details. You may use the reverse side if necessary.

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|--|-----|----|
| 1. Are you currently receiving, or have you received in the past two years counseling for the treatment of any emotional problems, drug additions, alcoholism, psychiatric condition, or eating disorder?  | Yes | No |
| 2. Do you have any significant chronic medical conditions requiring on-going medical supervision and treatment, or have you had in the past any significant condition which is currently in remission (ex. diabetes, heart problem, cancer, etc.)? | Yes | No |
| 3. Do you have any allergies (to medication, food, insects, etc.)?   |     |    |
| 4. Are you currently taking any prescription medication?   | Yes | No |
| 5. Will you require a continuation of medical treatment while you are participating in this study abroad program?  | Yes | No |
| 6. Will you require assistance for any physical disabilities while you are participating in this study abroad program?   | Yes | No |
| 7. Is there any additional information (concerning medical or mental health conditions or physical disabilities) that would be helpful for the program to be aware of during your study abroad experience?   | Yes | No |

With my signature, I certify that the information on this statement is correct. I authorize that this information may be forward to the International Director abroad and other necessary individuals connected with the administration of this program for use in a medical emergency. Finally, I give permission for the following person(s) to be contacted in the case of a medical emergency:

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime phone: \_\_\_\_\_ Fax \_\_\_\_\_

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Program: \_\_\_\_\_