

# University of Dallas Summer Programs

[ ] *Shakespeare's Baroque Rome* [ ] *Creative Writing/Poetry* [ ] *Creative Writing/Travel Writing*

## CONFIDENTIAL HEALTH STATEMENT of \_\_\_\_\_

(First Name)

(M.I.)

(Last Name)

Thank you for your interest in the University of Dallas Summer Programs Abroad. Our staff is dedicated to accommodating the various medical needs and disabilities of our travelers whenever possible. Because travel in the University of Dallas Summer Programs can often involve heightened medical stresses due, for instance, to differences in language and culture, full schedules, extensive walking, variable weather, uneven terrain, climbing stairs at monuments and other locations not handicapped accessible, difficulty in accommodating special dietary needs, and lack of access to appropriate medical assistance/facilities, the University therefore asks each traveler to provide complete and accurate health information in order to determine our group's specific needs in connection with participation in the program. All participants must be in good health and fully able to participate in all tour activities. Please note: There is no elevator at several of the museums and sites, and there are no grab bars in the bathrooms of the University dormitory.

This information is treated with the greatest possible confidentiality. It is viewed *only* by the program coordinator in order to assess staffing needs *and* by the program director if emergency medical service is required while on tour. Before departure we ask all travelers to update this information with any changes in conditions or medications. **Full disclosure is important** for proper care in case of emergency. To help ensure a traveler's safe participation, the University may ask that a traveler have a physician's examination or provide additional documentation to verify the traveler's physical and/or emotional ability to participate in the Summer Program. Failure to provide full, accurate and up-to-date health information may be grounds for a forfeiture of one's space in the program.

---

**Note: If none, write NONE or N/A.**

1. Please list any reason that change of diet, carrying luggage or strenuous travel overseas might present hardship for you.
2. Please list any religious or ethical dietary restrictions that you have (kosher, vegetarian, vegan, etc.)
3. Please list any food allergies that you have.
4. Please list any other allergies (including medication allergies such as penicillin):

---

5. Please list any and all medical conditions and concerns. Include any current or past physical or emotional conditions, concerns, or chronic illnesses. Even if you have overcome these problems, being in a new and challenging environment can cause recurrences. It is VERY important that staff know how to accommodate your needs. **(If none, write NONE or N/A)**

1) \_\_\_\_\_ Start date (approx): \_\_\_\_\_ End date (approx): \_\_\_\_\_

2) \_\_\_\_\_ Start date (approx): \_\_\_\_\_ End date (approx): \_\_\_\_\_

3) \_\_\_\_\_ Start date (approx): \_\_\_\_\_ End date (approx): \_\_\_\_\_

---

6. Please list any over the counter or prescription medication you take regularly or on an as needed basis. (include allergy shots if applicable) **(If none, write NONE or N/A)**

1) \_\_\_\_\_ For: \_\_\_\_\_ Date started: \_\_\_\_\_

2) \_\_\_\_\_ For: \_\_\_\_\_ Date started: \_\_\_\_\_

3) \_\_\_\_\_ For: \_\_\_\_\_ Date started: \_\_\_\_\_

Participant's initials: \_\_\_\_\_  
Please initial here and again on page 2

7. Have you consulted or been treated by physicians, clinics or other medical practitioners within the last two years (other than routine checkups)? Include hospitalizations. [ ] NO [ ] YES Please list diagnoses/treatments/dates:

8. Have you been treated by a psychologist or other mental health practitioner? [ ] NO [ ] YES If yes, please list dates, nature of concern and/or diagnoses, and treatments including medications and therapy. Attach separate sheet if necessary

9. Has your physical or working activity been restricted during the past two years? [ ] NO [ ] YES (Give reasons and duration)

10. Please list your family doctor:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

11. Please list any accident and medical insurance (valid outside the USA) by which you are covered. You are encouraged to purchase traveler's insurance.

Name of Policy Holder: \_\_\_\_\_ Company: \_\_\_\_\_

12. In case of emergency, contact (this should be an individual who has your power of attorney or access to any living will documentation):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact 2

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**CERTIFICATION OF INFORMATION:** I hereby certify that the answers I have made above are true, correct, and complete to the best of my knowledge. I have read and agree to the conditions stated at the top of this form.

**MEDICAL RELEASE:** In case of medical need, the Director of the University of Dallas Rome Program has the permission of the Undersigned to admit the Undersigned participant to the hospital or to contract with a physician for diagnosis and/or treatment. The Director or his delegate is also authorized by the undersigned, to carry the medical information on overnight trips and share with physicians in case of a medical emergency. The Undersigned assumes, jointly and severally, full financial responsibility for such diagnosis and/or medical treatment and agrees to indemnify the University of Dallas, its agents and employees against all such claims

Signature: \_\_\_\_\_ Date: \_\_\_\_\_