



Bluefield State College

Study Abroad Programs Health Form

This form is intended to determine your health history and any special medical needs you may have while you study abroad. Information provided will be treated confidentially, and any information considered important will be forwarded to your faculty leader or the host institution for the purpose of serving you as promptly and appropriately as possible should you require medical or counseling services during your time abroad.

First Name, Last Name								
BSC Student ID Number		E-mail		Phone				
Age		Gender		Height		Weight		
Generally, are you in good physical condition?		If NO, please explain.						
YES		NO						
Are you currently being treated for any physical condition?		If YES, please explain.						
YES		NO						
Are you taking any medications?		If YES, please explain.						
YES		NO						
Do you have any allergies to foods, medications, environmental factors, insects, etc.?		If YES, please explain.						
Do you have or have you ever been treated for:							YES	NO
Asthma or other Respiratory Problems								
Cardiac problems								
Diabetes								
Neurological Disorders								
Psychiatric Disorders (including eating disorders)								
Other Problems (if YES, please explain below)								

I certify that all responses made on this Health form are true and accurate, and I will notify the Study Abroad Advisor hereafter of any relevant changes in my health that occur prior to or during the program. I understand that this form is for information purposes only and in no way implies that Bluefield State College takes responsibility for my health.

Student Signature: _____ Date: _____