

Part I of the SIT Health Form must be submitted within **TWO WEEKS** of your offer of admission. Part I is to be completed online by logging in to your Applicant portal-under 'Confirmation Materials.' Part II of the health form must be completed by the confirmation materials due date. If this is not possible, then please let us know the date of your doctor's appointment for the completion of Part II. **Your completed health form must be received no later than November 30** for Spring semester, **June 15** for Fall semester, or **April 10** for Summer programs. Please upload the health form to your Applicant portal, scan to studenthealth@sit.edu, fax to 802 258-3509, or mail to: SIT Study Abroad, Student Health Office, PO Box 676, Kipling Road, Brattleboro, VT 05302-0676 USA

The guidelines below will assist you in completing your health form. Please be advised that leaving anything blank on your health form will delay your health clearance. Your health form will not be reviewed until all completed parts are received. Complete name and program at the top of all pages. Only SIT Study Abroad health forms will be accepted.

Please be sure to make a copy of the completed health form for your records.

PART I - Authorization and Personal Health History (pages 1-2)

- To be filled out by the student. Answer all questions in this section and submit with the rest of your confirmation materials.
- Please keep a copy of Part I for yourself and take it to the physician or medical professional who completes Part II.

PART II - Health Report and Examination (page 3)

- The completion of Part II must be based upon a physical examination conducted within 12 months of your program's start date. When making your appointment, be sure to inform your health care professional that you will also need the following test done on the same day:
 - ▶ An HIV test, only if you are participating in SIT Study Abroad/IHP programs to Bolivia or Mongolia (required as a part of these countries' visa processes and therefore cannot be anonymous). Entry requirements for a country may change frequently. Please consult your admissions counselor for further information.
- Part II is to be completed and signed by your physician, or health professional (nurse practitioner or physician's assistant).
- Immunization history is to be recorded in Part II or a copy of your immunization record may be attached. These records usually can be obtained from your physician's office, high school, university health center, or parents.

Please note: We do not accept reports completed by a physician who is related to you.

PART III A - Further Health Information for Overseas Travel: Medical (pages 4-5)

If you answered "yes" to any questions indicating a history of medical treatment under "Review of Illnesses and Symptoms" in Part I, please have your medical professional complete Part III A of this form.

PART III B - Further Health Information for Overseas Travel: Counseling and Mental Health (pages 6-7)

If you answered "yes" to any questions indicating a history of therapeutic treatment under "Review of Illnesses and Symptoms" in Part I, please have your mental health professional complete Part III B of this form.

CHANGE OF STATUS: You are responsible for notifying SIT immediately of any changes in your health history prior to your departure or while on the program.

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studyabroad@sit.edu | Tel 888 272-7881 | Fax 802 258-3509

Name _____ Gender _____ Birth date _____
last, first, middle month/day/year

Country and program title _____ Fall 20____ Spring 20____ Summer 20____

Telephone _____ School _____

Authorization to Release Health Records and Permission for Emergency Medical Treatment

Please complete and sign the following.

As an applicant to an SIT Study Abroad program, I, _____ hereby authorize the physician or other medical provider completing Part II and/or Part III of this Health Form, together with any other physician or medical provider who has provided information to SIT Study Abroad in connection with my application or participation in the Program, to release any or all health records or information pertaining to me to SIT Study Abroad. I also authorize the release by SIT Study Abroad of my health records or other medical information pertaining to me to my parent or other designated contact person in the event of an emergency.

On rare occasions, an emergency requiring treatment in a hospital and/or surgery may develop. In most cases, administration of an anesthetic, treatment of an injury, or operation upon an individual cannot be done without consent of the patient. In order to prevent a dangerous delay in an emergency situation where SIT Study Abroad is either unable to contact my parent or guardian, or if I am unconscious or otherwise unable to give you my consent, I hereby authorize SIT Study Abroad's representative to secure whatever medical treatment is deemed necessary, including administration of an anesthetic and surgery.

I hereby verify that all of the information contained in this form is accurate and complete and acknowledge that any failure to provide accurate and complete information, including notification to SIT Study Abroad of changes in my health affecting the accuracy or completeness of the information contained in this form, may result in my dismissal from the program. I agree to notify SIT Study Abroad of any material changes in my health that occur prior to the start of the program or while on the program.

Signature of applicant _____ Date _____

Printed name _____

Program title _____ Term/year _____

Students who would like information about the disability accommodation process should contact disabilityservices@sit.edu.

Participation in an SIT Study Abroad program is contingent upon review of a student's completed health form. SIT Study Abroad normally requires that all students participating in SIT Study Abroad programs show medical and psychological stability for six months prior to the group's departure date.

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Student's Name _____
Program _____

Review of Illnesses and Symptoms

Please check “yes” if you have experienced any of the following diagnoses or symptoms. Please give details below on any checked response, adding additional paper if necessary. **Part III of the health form is to be completed by your medical or mental health provider for any “yes” answers given in either the checkbox or question section of this health form.**

	yes		yes		yes
Abdominal problems		Cerebral palsy		Recurrent dizziness/faintness	
ADD/ADHD		Depression		Substance Use/Abuse	
Anemia		Diabetes		Thyroid disorder	
Anxiety		Eating disorder		Vision/eye problems	
Arthritis		Epilepsy (seizures)		Other (please specify)	
Asthma		Gastrointestinal disorder			
Autism/Asperger's (ASD)		Head injury/concussion		Allergy (please specify)	
Back problems		Heart murmur/disease		Hay fever	
Bipolar disorder		High blood pressure		Bees/wasps	
Bladder/kidney problems		Immune system problems		Pet/animal dander	
Bleeding/clotting disorder		Impaired use of any limbs		Foods	
Blood disorder		Joint problems		Drug	
Cancer or leukemia		Learning disability		Other allergy	
Celiac disease		Migraines or severe headaches			

Comment below on any condition(s) that you have checked “yes” above: _____

Please answer the following questions either ‘yes’ or ‘no.’ Do not leave any question blank.

A. Are you currently taking any medications (including antigen/immunotherapy allergy injections)? yes no
If yes, list and give details. _____

B. Have you ever been hospitalized? If yes, give diagnosis and date. yes no

C. Do you have any permanent injury or physical disability? If yes, give details. yes no

D. Do you have any health requirements or dietary restrictions? If yes, explain. yes no

E. In the last two years, have you received counseling or been treated for a mental health condition, substance abuse, or eating disorder? If yes, explain. yes no

The signature below confirms that I agree that SIT Study Abroad may share this information with its medical and mental health consultants for the purpose of completing the health review process, and that all information contained is accurate and complete.

Applicant's signature _____ Date _____



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Student's Name _____
Program _____

To the Examining Physician: SIT Study Abroad offers programs in all parts of the world, including remote areas of Africa, Asia, and Latin America. The type of program can vary—some include physically demanding components. All students will be fully active in the culture. Many will live with a family for a protracted period of time in varying conditions of sanitation and proximity to Western-style health facilities and psychological services. For these reasons you are asked to carefully consider the applicant's general fitness and physical and mental health in relation to the country, the type of program, and the conditions in which the applicant will be living. **Part III of the Health Form is to be used for further health information** and is to be completed by a physician or treating professional. This information is strictly for the use of SIT Study Abroad and will not be released without the applicant's consent.

Please fax immediately to 802-258-3509 or mail to:
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Immunization Record

Indicate the most recent date. The following immunizations are the minimum **REQUIRED**. Check Heath Guidelines for other country-specific required and recommended immunizations. Attach record if available. If proof of immunity is by titer, attach copy of lab report.

Tetanus/diphtheria/pertussis (Td or Tdap) ____/____/____ **Measles, Mumps, Rubella** (MMR #1) ____/____/____
Meningitis (certain programs in Africa) ____/____/____ **Measles, Mumps, Rubella** (MMR #2) ____/____/____

Height _____ Weight _____ How long have you known the applicant? _____

Please answer the following questions either 'yes' or 'no.' Do not leave any question blank.

1. Is this applicant seriously underweight or overweight? yes no
2. Is there a history of any eating disorder, such as bulimia or anorexia, within the last two years? yes no
3. Does this applicant have any allergies (including allergies to medication and/or food)? yes no
4. If applicant has allergies, is there a history of asthma, anaphylaxis, and other dangerous allergic conditions? yes no
5. Is this applicant currently under medical treatment or taking medication? yes no
6. Does this applicant have any speech, hearing, eyesight, or physical impairment? yes no
7. If answer to Question 6 is yes, would this applicant have difficulties participating in an academically challenging and rigorous summer abroad program? yes no
8. Has the applicant received counseling or mental health treatment within the last two years? (If "yes," permission will be asked of the applicant for a confidential report from the treating professional.) yes no
9. Is there any congenital or chronic condition that may require additional treatment? yes no
10. Would carrying luggage, or conducting strenuous travel, cause the applicant hardship? yes no
11. Are there limitations to physical activity? If yes, give details below yes no

Please give details on any checked "yes" responses. Part III is to be used for further health information. _____

Having examined this applicant and reviewed his/her past medical history, I agree that the applicant is healthy enough to participate in the 20__ program indicated above.

Signature of physician or medical professional _____ Date _____

Name (print) of physician or medical professional _____

Address of physician or medical professional _____
city, state, zip code

Telephone _____ Fax _____
include area code or country and city codes include area code or country and city codes

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Student's Name _____
 Program _____

4. Are there currently any problems or issues of concern regarding this condition? (Describe plans for testing or treatment.)

5. What is the prescribed plan in the event that this health condition becomes an acute emergency overseas?

6. What are the limitations, if any, on this applicant's participation in an extremely rigorous (emotionally and physically) overseas program?

Medical Professional's Authorization

I, _____, consider that _____
name of medical or treating professional name of applicant

is fit to participate in _____ in _____
country program

during (circle one) the fall / spring / summer 20_, and will send along with said applicant any medical records needed for possible treatment by a physician or medical facility abroad. Having received permission from said applicant, I am willing to further discuss problems pertaining to this issue with the professional staff of SIT Study Abroad.

Signature of medical or treating professional _____ Date _____
month/day/year

Mailing address _____
city state postal code country

Telephone _____ Fax _____
area code or country and city codes area code or country and city codes



To the Appropriate Mental Health Professional:

Studying abroad can be an enriching experience as well as a physically and mentally challenging one. Mild or pre-existing health conditions can become serious for some students as they transition into an unfamiliar culture and environment. For this reason, we encourage all students to fully disclose their health history so that we can prepare them properly for their experience, make arrangements for any special accommodations if necessary, and in some cases, assess whether there may be any health reasons that an applicant should consider another program.

In order to ensure the applicant's well being, we expect full disclosure of any health history that could be potentially problematic for a student overseas. Please give as much detail as possible in answering the following questions.

Please fax immediately to 802-258-3509 or mail to:

SIT Study Abroad, Student Health Office, PO Box 676, Kipling Road, Brattleboro, Vermont 05302 USA

Please include appropriate relevant medical records and any information necessary for medical personnel overseas who might be treating this student. Please use additional paper if necessary.

1. Describe, in as much detail as possible, the relevant mental health condition and/or precipitating event(s) that led the applicant to seek counseling. State DSM-5 diagnosis(es) if applicable; please list the applicant's specific symptoms.

2. When did the applicant experience this condition, and when was the applicant diagnosed? Please list specific dates.

3. How was this condition treated and for how long? Include dates and type of treatment, name and dosage of medication(s) etc.

4. Describe any triggers that might lead to the recurrence of symptoms.

