

STUDENT HEALTH FORM

(To be completed by the student)

Summer 2016

STUDENT'S NAME: _____ DATE OF BIRTH _____

PERMANENT ADDRESS: _____

COLLEGE ADDRESS: _____

The purpose of this form is to help the *Institut* be of maximum assistance to you should the need arise while you are studying in France. Mild physical or psychological disorders can become serious under the stresses of life in an unfamiliar environment. It is important that we be made aware of any medical or emotional problems, past or current, which might affect you in a foreign study context. The information provided by you and your physician(s) will remain confidential and will be shared with program staff, faculty, or appropriate professionals only if pertinent to your own well-being. Your application will not be rejected on the basis of either a physical or an emotional condition unless it is of such a serious nature or degree as to prevent your successful participation in the program, or unless appropriate medical care for the medical problem is not available in the program, and/or unless the living and environmental conditions to which you could be exposed would present a risk to your health.

- Yes No 1. Are you in generally good physical conditions? (If no, explain)
- Yes No 2. Have you ever been or are you currently being treated for any psychological or emotional problems? (If yes, have your physician or counselor attach a note of explanation)
- Yes No 3. Do you have any allergies? (If yes, explain)
- Yes No 4. Are you taking any medications? (If yes, explain for what ailment)
- Yes No 5. Have you had any major injuries, diseases, or ailments in the last five years? (if yes, explain)
- Yes No 6. Are you a vegetarian or are you on a restricted diet? (If yes, explain)
- Yes No 7. Is there any additional information regarding your medical or emotional condition or regarding physical or learning disabilities that we should know about before your study abroad? (If yes, explain)

I certify that all responses made on this health information form are true and accurate, and that I will notify the *Institut* hereafter of any relevant changes in my health that occur prior to the start of the program.

SIGNATURE: _____ DATE: _____

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Please return this form by May 2, 2016