

UHV HEALTH DISCLOSURE

In the event of any medical emergency (physical or mental), Student hereby grants to University of Houston-Victoria or any of its representatives on the Program the full authority to take any action deemed necessary to protect Student's mental or physical health and safety at Student's own expense, including, but not limited to, placing Student under the care of a doctor or in a hospital or any place for medical examination and/or treatment or returning the Student to the United States at Student's own expense if such return is deemed necessary after consultation with medical authorities. In the event Student is returned to the United States, Student shall not recover any money paid for and in connection with the Program. Student agrees University of Houston-Victoria is not required to take any such actions if it is not aware of the emergency or in its discretion determines no emergency exists. Should the need arise, University of Houston-Victoria representative is authorized to provide any personal information of Student to any health care provider.

Please read these forms and follow all instructions for completion. **FULL DISCLOSURE REQUIRED.** The information on these forms will assist health care providers in the event of a medical emergency. It is very important that all sections are completed fully and accurately. If a question is not applicable, enter N/ A

STUDENT'S FULL NAME: _____
HOME ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ WORK PHONE: _____

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First Emergency Contact:

Name: _____ Relationship: _____
Address: _____ City: _____ State _____ Zip _____
Home phone: _____ Work Phone: _____ Other: _____

Second Emergency Contact:

Name: _____ Relationship: _____
Address: _____ City: _____ State _____ Zip _____
Home phone: _____ Work Phone: _____ Other: _____

Primary Care Physician:

Name: _____ Office Phone: _____
Insurance Carrier: _____ Policy Number _____

Medical insurance is highly recommended for course participation. Health care providers may require proof of ability to pay for services before services are rendered. If you do not have health insurance, trip insurance may be purchased from an independent insurance agency. If you purchase temporary health insurance, you must provide the name of the carrier and the policy number in the blank provided.

MEDICAL HISTORY : All questions **must** be answered by marking Yes or No. For each "Yes" provide an explanation in the area provided below. Attach an additional sheet if necessary.

Do you currently have or have you ever had a history of:

- Yes No Allergies to foods, medication, plants or animals/insects?
- Yes No Altitude sickness?
- Yes No anaphylactic reactions?
- Yes No Arthritis?
- Yes No Bleeding disorders?
- Yes No Cardiac/circulatory problems?
- Yes No Chemical abuse or dependency? (drugs, alcohol, etc.)
- Yes No Diabetes?
- Yes No Eating Disorders including anorexia and/or bulimia?
- Yes No Endocrine problems?
- Yes No Epilepsy?
- Yes No Frostbite or abnormal intolerance to cold temperatures?
- Yes No Gastrointestinal problems?
- Yes No Heat exhaustion/heat stroke intolerance to hot temperatures?
- Yes No Hypertension?
- Yes No Knee, ankle, back, or other skeletal problems including, but not limited to sprains, fractures or operations?
- Yes No Liver dysfunction?
- Yes No Lymphatic problems?
- Yes No Menstrual cramps?
- Yes No Muscular problems?
- Yes No Neurological problems?
- Yes No Premenstrual syndrome?
- Yes No Psychiatric treatment or psychological counseling?
- Yes No Reproductive organ problems?
- Yes No Respiratory problems including but not limited to asthma, chronic, bronchitis, or allergies?
- Yes No Thyroid problems including allergy to iodine?
- Yes No Urinary tract disorders?
- Yes No Are you pregnant?
- Yes No Are you currently seeing a doctor or health specialist?
- Yes No Are you currently taking any non-prescription medication? (name and reason)
- Yes No Are you currently taking any prescription medication? (name and reason)
- Yes No Do you have any dietary restriction?
- Yes No Do you wear contact lenses?
- Yes No ALLERGIES to MEDICATION or OTHER SUBSTANCES
- Yes No Other Allergies - Specify
- Yes No SERIOUS INJURIES or OPERATIONS (Describe/Date)
- Yes No TOBACCO USAGE If Yes – what type (Cigarettes, cigars, pipes, or chewing tobacco, etc)

Please use this space to completely explain all “Yes” answers. Use separate sheet of paper if necessary. Be advised that some medical conditions may require doctor’s approval for participation in this course.

IMMUNIZATIONS: Please indicate the DATE of your last immunization for Diphtheria/Tetanus

__ / __ / __

PERMANENT DISABILITIES (Describe/Date)

Preferred method of contact: Home _____ Work _____ Cell #
Pager# _____ Email _____

I verify that all information in this health disclosure is complete, accurate and true to the best of my knowledge.

Signature

Print Your Name

Date

State law requires that you be informed of the following: (1) you are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law). (2) you are entitled to receive and review that information; and (3) your are entitled to have the information corrected at no charge to you