ACT | a division of Anatolia College

HEALTH ASSESSMENT FORM

The information provided in this form will be kept strictly confidential and only used to aid professional response in the case of student illness or emergency; and/or for the prevention of such illness or emergency. Please submit the completed form(s) through your ACT application portal.

If there is not enough space provided on the form, please continue on a separate page.

Applicant name: _____

Home School: _____

PART 1
Self-Assessment Questions

1 Do you have any disabilities for which you will need accommodations abroad, including academic accommodation? Yes ☐ No ☐

If **yes**, have you informed your institution's office that supports study abroad students? Yes ☐ No ☐

Please provide more information about your disabilities and required accommodations:

2 Are you on a restricted diet? Yes ☐ No ☐

If **yes**, please provide more information about your diet:

3 3a. Do you have any food, drug, animal, insect, or other allergies? Yes ☐ No ☐

If **yes**, please provide more information about your allergies:

3b. If you have allergies, are your allergy symptoms life-threatening? Yes ☐ No ☐

Please provide more information about your allergy symptoms, treatment and management:

3c. Do you carry an EpiPen or similar? Yes ☐ No ☐

4 Do you plan to take prescription medications while abroad? Yes ☐ No ☐
If **yes**, please provide more information (medication name and dosage):

5 Have you been treated in the last **five** years, or are you currently being treated for any of the following conditions?

▪ Immunodeficiency	Yes ☐	No ☐
▪ Severe Migraine	Yes ☐	No ☐
▪ Seizures	Yes ☐	No ☐
▪ Cardiopulmonary Disorder	Yes ☐	No ☐
▪ Asthma	Yes ☐	No ☐
▪ Tuberculosis	Yes ☐	No ☐
▪ Coeliac Disease, Crohn's Disease or Ulcerative Colitis	Yes ☐	No ☐
▪ Lyme Disease	Yes ☐	No ☐
▪ HIV/AIDS	Yes ☐	No ☐
▪ Hepatitis	Yes ☐	No ☐
▪ Diabetes	Yes ☐	No ☐
▪ Substance abuse	Yes ☐	No ☐
▪ Eating Disorder	Yes ☐	No ☐
▪ Anxiety	Yes ☐	No ☐
▪ Depression	Yes ☐	No ☐
▪ Bipolar Disorder	Yes ☐	No ☐
▪ OCD	Yes ☐	No ☐
▪ Psychoses	Yes ☐	No ☐
▪ Personality Disorder	Yes ☐	No ☐
▪ ADD or ADHD	Yes ☐	No ☐
▪ Other (please describe)	Yes ☐	No ☐

Please provide more information here about your condition and treatments needed while abroad:

PART 2
Action Steps Based on Answers to Part 1

☐ I have answered ***no*** to all questions **#1-5** in Part 1, and believe that no additional action on my part is necessary to safeguard my health abroad.

☐ I answered ***yes*** to one or more of questions **#1-3a** in Part 1 and will discuss my healthcare needs and action plan with one or more of the following: a representative from my home institution's unit coordinating my program, a representative from the program provider or host institution, a healthcare professional, parents or other family members well in advance of my departure date.

☐ I answered ***yes*** to question(s) **#3b, 3c, 4, & / or 5** in Part 1 and understand that I must complete and submit Part 3 to ACT after having it completed by a physician and/or mental health professional providing care for my indicated condition or by another professional qualified to advise on my care.

STUDENT'S SIGNATURE: _____ DATE: _____

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PART 3

Healthcare Provider Evaluation

(Only required for students who answered yes to questions #3b, 3c, 4, &/or 5 on Part 1 of the self-assessment checklist)

To the healthcare provider: Thank you for taking the time to meet with this student and complete this form. The student has indicated in Part 1 of this healthcare assessment form that s/he suffers from a life-threatening allergy; and/or that s/he plans to take prescription medications while abroad; and/or that in the last five years s/he has been treated for one or more of the conditions listed in question #5 of the self-assessment. Living and studying in an unfamiliar environment can trigger physical and emotional stress, and exacerbate existing physical or mental health issues. You are asked to:

- Complete this evaluation form. Please use additional pages, if necessary.
- Discuss the student's medical situation with him/her in light of how it may affect the student's study abroad experience.
- Discuss possible accommodations that the student should make or discuss with staff administering or overseeing their overseas program/experience.

STUDENT'S NAME: _____

1 Is the applicant prescribed medication, including medication for a life-threatening allergy? If so, please list the medication with dosage and directions in the space following. Note that it is recommended that the applicant bring a full supply of the medication, in the original packaging, for the duration of their period abroad.

☐ No ☐ Yes

_____
_____
_____
_____
_____

2 If the student has indicated that s/he has been treated in the last **five** years or is currently being treated for any of the conditions in self-assessment question #5, please describe the condition, treatment and any other relevant information in relation to the time the student will be abroad.

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3 Do you have any concerns about the applicant's ability to physically or mentally participate in the Study Abroad Program of the American College of Thessaloniki?

☐ No ☐ Yes (please describe)

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_____

4 To your knowledge, are there any predisposing physical or emotional factors that, under the stress of adjusting to life in another country, may require treatment while the student is abroad?

☐ No ☐ Yes (please describe)

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5 Is there any additional information that would be helpful to ACT staff administering the ACT program, including the ACT physician and the ACT counselor?

☐ No ☐ Yes (please describe)

_____
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_____

HEALTHCARE PROVIDER STATEMENT

I have examined (student's name) _____
and consider him/her physically and mentally ***QUALIFIED / UNQUALIFIED*** *(circle one) to participate in the American College of Thessaloniki Study Abroad program. I certify that the above statements are true and complete to the best of my knowledge.*

Signature: _____ Date: _____

Name: *(PLEASE PRINT)* _____

Profession: _____

Phone number: _____ email address: _____

Address: _____

City : _____ State: _____ Zip: _____