MAITRI
GLOBAL EDUCATION

Health Information Form

It is important that MGE be aware of your health-related needs and/or concerns.

We encourage you to consider the importance of these matters as you plan to go abroad.

This information is not used to determine eligibility for the program.

Mr. / Ms. Last Name

First Name   Middle Name

Term Abroad ____________________

1. Your general state of health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Please describe any general health concerns you have at this time.

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3. Please list any serious medical conditions for which you have been (or are currently being) treated.

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4. Have you ever had (if yes, please give details of the condition and treatment on back)

Heart trouble or blood pressure problems?	☐ Yes	☐ No
Asthma or any other respiratory ailment?	☐ Yes	☐ No
Stomach or intestinal problems (ulcers, etc.)?	☐ Yes	☐ No
Allergic reaction to any medications?	☐ Yes	☐ No

5. Do you require any regular medication? If yes, please describe conditions and requirements.

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AITRI
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Health Information Form

6. Have you ever been / are you currently being treated for any mental, emotional, or nervous disorder? If yes, please describe.

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7. Name, address, and telephone of your physician or practitioner:

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8. You will need to have health insurance coverage for the period you are away from your home institution which is accepted by the Italian authorities.

However, should you have additional insurance coverage which you have arranged yourself that will cover you from the time you leave your home university until your time abroad is over, please list the details below.

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____

Other coverage: ____

Policy holder (parent, etc.) ____

Insurance company name ______________________ and policy no. ______________

I understand that pre-existing health conditions may impact the quality and safety of my education abroad experience. I also realize that is my responsibility to contact my physician or health practitioner about conditions which may be affected by my change of location.

______________________ ______________________

Signature Date