SIT | Graduate Institute

HEALTH FORM INSTRUCTIONS

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

Part I of the SIT Health Form must be submitted within **TWO WEEKS** of your offer of admission. Please let us know the date of your doctor's appointment date for the completion of Part II. **Part II of the health form must be received no later than May 30.** Please email the health form to studenthealth@sit.edu, fax to 802 258-3509, or mail to: SIT Graduate Institute, 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 Graduate Institute 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.
- 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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PART I: AUTHORIZATION AND PERSONAL HEALTH HISTORY

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Name_____ Gender_____ Birth date_____
last, first, middle month/day/year

Degree Program Name_____ Year_____

Authorization to Release Health Records and Permission for Emergency Medical Treatment

Please complete and sign the following.

As an applicant to an SIT Graduate Institute 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 Graduate Institute in connection with my application or participation in the Program, to release any or all health records or information pertaining to me to SIT Graduate Institute. I also authorize the release by SIT Graduate Institute 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 Graduate Institute 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 Graduate Institute'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 Graduate Institute 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 Graduate Institute 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 Graduate Institute program is contingent upon review of a student's completed health form. SIT Graduate Institute normally requires that all students participating in SIT Graduate Institute 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)? If yes, list and give details. ☐ yes ☐ no

_____

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 consulted 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 Graduate Institute may share this information with its medical 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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PART II: HEALTH REPORT AND EXAMINATION

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Student's Name_____
Program_____

To the Examining Physician: Please give details below on any questions to which you have answered yes or on any points of concern in your examination or in this applicant's personal health history in Part I. **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 and SIT Graduate Institute 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

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

Tetanus/diphtheria/pertussis (Td or Tdap) _____/_____/_____
Meningitis (Recommended) _____/_____/_____
Measles, Mumps, Rubella (MMR #1) _____/_____/_____
Measles, Mumps, Rubella (MMR #2) _____/_____/_____

Height _____ Weight_____

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 an 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?	☐ n/a ☐ 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 program?	☐ n/a ☐ 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

_____

_____

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, zipcode

Telephone_____ Fax_____
include area code or country and city codes — include area code or country and city codes

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PART III A: HEALTH INFORMATION FOR OVERSEAS TRAVEL, MEDICAL

Student's Name_____
Program_____

To the Appropriate Medical 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 a student 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 Graduate Institute, 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.

1. Describe, in as much detail as possible, the relevant health condition. (For allergies, please indicate what this applicant is allergic to, how he or she reacts to it, and any medications that should be used by the applicant overseas.)

2. When did the applicant experience this condition, how did it occur, and when was the applicant diagnosed? (Give specific dates.)

3. How was this condition treated and for how long? (Give specific dates, medications, etc.)

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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, _____ (name of medical or treating professional), consider that _____ (name of applicant)

is fit to participate in _____ (program)

during 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 Graduate Institute.

Signature of medical or treating professional_____ Date_____ (month/day/year)

Mailing address_____ (city, state, postal code, country)

Telephone_____ (area code or country and city codes) Fax_____ (area code or country and city codes)

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PART III B: HEALTH INFORMATION FOR OVERSEAS TRAVEL, COUNSELING & MENTAL HEALTH

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Student's Name_____
Program_____

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 a student 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 Graduate Institute, 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.

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Student's Name_____
Program_____

5. List specific coping strategies that this applicant has used for this condition and other stressful situations.

6. Are there any current problems or concerns regarding this condition? If so, please explain, along with any recommendations.

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

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

Mental Health Professional's Authorization

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

is fit to participate in _____
program

during 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 Graduate Institute.

Signature of medical or treating professional_____ Date_____
month/day/year

License_____ Title_____

Mailing address_____
city — state — postal code — country

Telephone_____ Fax_____
area code or country and city codes — area code or country and city codes