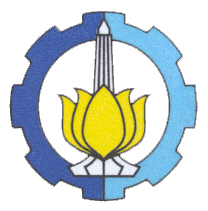
**MINISTRY OF EDUCATION, CULTURE,** **RESEARCH, AND TECHNOLOGY**

**INSTITUT TEKNOLOGI SEPULUH NOPEMBER**

**DIRECTORATE OF GLOBAL ENGAGEMENT**

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<https://www.its.ac.id/>; <https://www.its.ac.id/international/>

Health Information Form

Thank you for your interest to have an academic experience at ITS. It is important that we be aware of any past or current medical issues, including mental health conditions, which might affect your study. This information will be kept confidential to protect student privacy. Disclosure of such information may be made to appropriate individuals (including program staff and resident directors) and to provide you with assistance should the need arise during your study. Health tests, certifications, or other actions may also be required prior to departure in certain circumstances.

Global Engagement ITS is committed to enabling participation in its programs for all qualified individuals. If you have questions, need assistance, or wish to discuss accommodations for health problems, please contact your buddy and/or the office. Accommodations may require extensive planning and communications with foreign contacts, so adequate lead time is critical. Contact should accordingly be initiated as soon as possible.

**PART A: GENERAL INSTRUCTIONS:**

Completing and having this is a condition of study in ITS programs

Please complete this form in English either by typing or by hand, using black ink and in capital letters.

* You must notify ITS IO of any relevant changes to the information that may occur prior to the program.
* The information in this form is confidential.
* Please take the signed original of this form plus any supporting documents.

**PART B: HEALTH HISTORY**

In case of hospitalization by ITS, student’s medical records are available from:

|  |  |
| --- | --- |
| Physician / Hospital : |  |
| Telephone Number : |  |
| Address: |  |

Has the student ever had any infectious diseases?  No  Yes. If yes, please tick  any that apply:

|  |  |  |  |
| --- | --- | --- | --- |
|  Measles (Rubeola) |  Encephalitis |  Hepatitis (specify) |  Frequent tonsillitis |
|  Rubella (German measles) |  Pneumococcal infection |  Yellow fever |  Bronchitis |
|  Staphylococcal infection |  Streptococcal infection |  Other, please specify: | |

Please provide a brief history/explanation regarding above and whether they have left any lasting complications:

Does the student have any recurring medical problems or chronic conditions?  No  Yes. If yes, please tick  any that apply:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anemia/blood disorder | Eating disorder | HIV | Migraines/headaches |  |
| Asthma | Hypertension | Kidney disease | Mobility limitations |  |
| Autism/Asperger’s Syndrome | Diabetes | Learning disability | Tuberculosis |  |
| Lupus | Cardiovascular disease | Mental health concern | Color blind |  |
| Attention deficit hyperactivity disorder (ADHD/ADD) | Epilepsy | Other, please specify: | |  |

Please specify if there is anything that ITS staff should be aware of relating to any of the above:

**PART C: CURRENT MEDICATIONS AND NEEDS**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Name: | |  |  |  |  | | |  |  |  |
|  | |  | *Last* |  | *First/Given* | | | *Middle* |  |  |
| Gender: **** Male | |  | Date of Birth: | **\_\_ \_\_ \_\_ \_\_** | | **\_\_ \_\_ \_\_ \_\_** | | Country of Citizenship: |  |  |
| **** Female | |  |  |  |  |  |
|  | |  |  | *dd* | *mm* |  | *yyyy* |  |  |  |
|  | | |  | |  |  |  |  | |  |
| Department/Degree: | | | | |  |  | Duration of program (start date and end date): | | |  |
|  | |  |  |  |  |  | Start date: | End date: |  |  |
|  | | | |  |  |  |  |  |  |  |
|  | | | |  |  |  |  |  |  |  |
| In case of emergency, please contact: | | | |  |  |  | Language(s) spoken: |  |  |  |
|  |  | |  |  |  |  |  | |  |  |
| Contact number (Home): |  | |  |  |  |  | Contact number (Office and/or Mobile): | |  |  |
| - | - | | |  |  |  | - | - |  |  |
| *country code* | *Area code* | | | *number* |  |  | *country code* | *area code* | *number* |  |
|  |  | |  |  |  |  |  |  |  |  |

**Diet**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Do you require a special diet? | Yes  No  |  |  |  |
|  | If yes, please give details: |  |  |  |  |
|  | Are there any foods that you | Yes  No  |  |  |  |
|  | cannot or should not eat? |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |
|  | If yes, please give details: |  |  |  |  |
| **Allergies** | |  |  |  |  |
|  |  |  |  |
|  | Do you have allergies to: |  |  |  |  |
|  | Food | Yes  No  | If yes, please specify: |  |  |
|  | Medicines | Yes  No  | If yes, please specify: |  |  |
|  | Others | Yes  No  | If yes, please specify: |  |  |
|  | What medications can you be given for an allergic reaction? | |  |  |  |

**Medications**

Do you take any medications? \*)\*\*)

|  |  |  |  |
| --- | --- | --- | --- |
| Brand Name | Generic Name | Dose, Schedule, Special Instruction | If it is a prescription, is it renewable? |
|  |  |  | Yes No  |
|  |  |  | Yes No  |
|  |  |  | Yes No  |

*\*)Please ensure sufficient supply for the study’s duration.*

**Special Needs**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have any special needs or require any specific support? |  | Yes  No  |  |
|  |  |

If yes, please specify:

*\*\*)Bringing any specific medical documentation would be very helpful for a doctor in the host country. Bringing it with you can help avoid unnecessary and expensive procedures. It is recommended that you discuss this with your regular physician.*

**PART D: HEALTH INSURANCE**

Are you holding health insurance? No  Yes 

**If no**, it is strongly recommended that you make your own health insurance. If you are not going to have health insurance, you are aware that all expenses that may happen because of your health problems will be you or your parents’ responsibility.

**If yes**, please make sure that your health insurance is applicable in Indonesia.

Primary Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART E: CERTIFICATION**

*I certify that all responses made on this form are true, accurate and complete, and I will notify ITS IO of any relevant changes that may occur prior to or during my study program. I have included in this form, advised the ITS IO Staff of any special needs or assistance that I/the student may have relating to my/the student’s physical and mental health. I am aware that if I do not provide complete information, this may cause hardship and concern to others and may affect my/the student’s own welfare. I understand that if I do not provide complete information, ITS IO may decide to send me/the student home from the study program at my/the student’s own expense.*

*I consent to the release of medical information to ITS IO or its agents so that they may provide me with needed assistance. I further agree that ITS IO or its agents may release information to other persons who may need this information to assist me/the student or to assist others in my study. I understand and agree that this form may be released to the ITS IO staffs for such purposes.*

*I am aware that I am responsible for my/the student’s physical and mental health and will cover any medical expenses that may occur during my/the student’s study at ITS.*

*If my parents or guardians have not signed this form, I represent and certify that I am not a minor according to the laws of my country.*

Tick if this is the case 

Signature of Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian

of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_