## **AIFS STUDENT ACCESS INFORMATION FORM**

## Individuals with Mental Health Disabilities

The information provided below will help start our discussions with you in planning for any access or resources you will need while on your study abroad program. Please complete the form with any pertinent information and email it to the Admissions Officer of your intended study abroad program location.

Although AIFS is committed to supporting all students in their study abroad journey, we cannot guarantee that it will be possible to honor all accommodation requests. AIFS staff will review all requests, consult with onsite staff and host institutions and communicate with you throughout this process. Please check this box if you consent to AIFS sharing this form with staff of the education abroad office at your home institution. **Confidentiality:** You are not required to answer any or all questions. Information that you provide on this form will remain confidential and will be used to ensure your full participation in your AIFS Study Abroad program. This form was designed from recommendations made by Mobility International USA. **STUDENT INFORMATION** Student's Name \_\_\_\_\_ Home Institution \_\_\_\_\_ Email Study Abroad Program \_\_\_\_\_\_ Program Term and Year \_\_\_\_\_ **Disability Overview** 1. In your own words, please describe your disability:

2.	Please describe any accommodations you currently receive at your home institution:
3.	How does your disability affect you on a day-to-day basis (if at all)?

	hat events or behaviors worsen your disability? (For example, stress, lack of sleep, large groups, skipping eals, alcohol, etc.)
rvi	ces & Medications
	re you participating, or have you participated, in treatment or services related to your mental health? dicate on each line if you are currently using this service or have used it previously:
a)	Outpatient treatment/ Talk therapy
b)	Case management
c)	Residential services
d)	Medication management
e)	Inpatient treatment
f)	Substance use services
g)	Emergency services
h)	
	Medicaid Waiver (U.S. respondents only)
i) .,	
j)	Representative Payee
k)	Other (Describe)

a. b. c. d. secon a. b. c. d.	How often do Indicate num. When do you (e.g. morning) When does you what side eff	Yes No unt:  o you take this medication?  ober of times/-day OR as needed  u take this medication?  g, evening, with meals, other)  your current prescription expire?
b. c. d. e. f. g. Secon a. b. c. d.	How often do Indicate num. When do you (e.g. morning) When does you what side eff	unt: o you take this medication? aber of times/-day OR as needed u take this medication? g, evening, with meals, other)
c. d. e. f. g. Secon a. b. c. d.	How often do Indicate num. When do you (e.g. morning) When does you what side eff	o you take this medication?
d. e. f. g.  Secon a. b. c.	When do you (e.g. morning) When does you what side eff	u take this medication?
e. f. g.  Secon a. b. c. d.	When do you (e.g. morning) When does you	u take this medication?
e. f. g.  Secon a. b. c. d.	(e.g. morning) When does you What side eff	g, evening, with meals, other)
f. g.  Secon a. b. c. d.	When does y	
f. g.  Secon a. b. c. d.	What side eff	our current prescription expire?
g.  Secon a. b. c. d.		
Secon a. b. c.		fects do you experience?
a. b. c. d.	What effects	do you experience when you miss a dose?
c. d.		Yes No unt:
d.		o you take this medication?
		ber of times/-day OR as needed
e.	When do you	u take this medication?
e.	(e.g. morning	g, evening, with meals, other)
	When does y	our current prescription expire?
f.	What side eff	fects do you experience?
g.	What effects	do you experience when you miss a dose?

Third Medication Name:					
	Generic? Yes No				
b.	Dosage Amount:				
c.	How often do you take this medication?				
	Indicate number of times/-day OR as needed				
d.	When do you take this medication?				
	(e.g. morning, evening, with meals, other)				
e.	When does your current prescription expire?				
f.	What side effects do you experience?				
g.	What effects do you experience when you miss a dose?				
lease	list additional medications on a separate page.				
re yo	u taking any non-prescription (over-the-counter, herbal, etc.) medications?				
Vhich	of these medications are you planning to bring with you abroad?				
aging	Daily Living				
	Daily Living aware of your disability?				
Vho is	aware of your disability?				
Vho is					
Vho is	aware of your disability?				
Vho is	aware of your disability?				
_	b. c. d. e. f. g.				

Ho	How do you communicate with the people in your support network?	
b.	What are your most effective coping strategies?	
c.	How do variations in your routine affect you (mood, medication compliance, self-care, etc.)?	
d.	In the past year, how many times have you missed school, work, or family events because of your symptoms or treatment?	
e.	What academic accommodations have been helpful to you in the past?	
Ha	ndling Crisis	
10	. Do you experience crisis episodes, including panic/anxiety attacks or psychosis?	

a.	How do you recognize when you are in crisis/-need emergency or urgent care? What thoughts or behaviors are clues?
— b. —	During crises, do you typically seek out services yourself or do others recommend additional services?
11	. Do you currently have, or have you previously used, a safety plan to help you manage your symptoms?
12	. Have you ever encountered legal or disciplinary issues as a result of your disability? What sanctions or legal consequences, if any, were imposed?
13	. Do you currently have, or have you previously used, a behavioral contract to help you manage your behaviors? If yes, please provide details.
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Further Information		
14. Have you ever had thoughts of harming yourself or someone else? If yes, is this current or how long ago was the last time you had these thoughts?		
a. Have you ever made an attempt before? If so when did this happen?		
15. Do you self-injure, or have you self-injured in the past? If yes, is this happening currently or how long ago did you self-injure?		
16. Have you ever been diagnosed with an eating disorder? If yes, when did you have or do you currently have an eating disorder?		
17. Have you ever experienced hallucinations or delusions?		
Travel		
18. How do you typically approach speaking in public or new situations or people?		

19. What sources of information have you used to learn about mental health services and cultural attitudes in the host country?
20. Do you have comments, concerns or questions about your travel? Please explain.
Please email this form to the Admissions Officer of your intended study abroad program location as soon as possible.