PARTICIPANT INFORMATION FORM

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/intern abroad program. Please complete the form with any pertinent information and email it to the Program Advisor of your intended study/intern abroad program location.

Although AIFS Abroad is committed to supporting all participants in their study abroad/ intern journey, we cannot guarantee that it will be possible to honor all accommodation requests. AIFS Abroad staff will review all requests, consult with onsite staff and host institutions and communicate with you throughout this process.

If additional space is needed than what is provided we welcome you to add additional word doc with the form title, question number and your response.

❑ **Please check this box if you consent to AIFS Abroad 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 suggestions made by Mobility International USA.

Participant Information

Participant's Name

Home Institution

Email

Study/Intern Abroad Program

Program Term and Year

Mental Health Overview

1. In your own words, please describe your mental health challenges:

2. Please describe any accommodations you currently receive at your home institution:

3. How does your mental health challenges affect you on a day-to-day basis (if at all)?

4. What events or behaviors worsen your mental health challenges? (For example, stress, lack of sleep, large groups, skipping meals, alcohol, etc.)

Housing

5. Are there any reasonable adjustments that you would require related to your housing?

- ❑ Yes
- ❑ No

If yes, please describe below:

Services & Medications

6. Are you participating, or have you participated, in treatment or services related to your mental health? Indicate on each line if you are currently using this service or have used it previously:

Outpatient treatment/ Talk therapy

- ❑ Currently using
- ❑ Previously used

Case management

- ❑ Currently using
- ❑ Previously used

Residential services

- ❑ Currently using
- ❑ Previously used

Medication management

- ❑ Currently using
- ❑ Previously used

Inpatient treatment

- ❑ Currently using
- ❑ Previously used

Substance use services

- ❑ Currently using
- ❑ Previously used

Emergency services

- ❑ Currently using
- ❑ Previously used

Disability Benefits from Governments (e.g. SSI or SSDI for U.S. respondents)

- ❑ Currently using
- ❑ Previously used

Medicaid Waiver (U.S. respondents only)

- ❑ Currently using
- ❑ Previously used

Representative Payee

- ❑ Currently using
- ❑ Previously used

Other - Please Describe:

7. Are you taking any non-prescription (over-the-counter, herbal, etc.) medications

8. Which of these medications are you planning to bring with you abroad?

9. Do you take prescription medication to manage your mental health challenges.
   - ❑ Yes
   - ❑ No

   a. If yes, please list your current prescriptions. Include the name of each medication, the prescribed dosage, and the time of day you typically take each medication.

      First Medication Name:

      a. 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?

Second Medication Name:

a. 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?

Third Medication Name:

a. 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?

10. Please list additional medications on a separate page.

Managing Daily Living

11. Who is aware of your mental health challenges?

12. Who do you include in your support network? Will you be able to communicate with them?

13. How do you communicate with the people in your support network?

14. What are your most effective coping strategies?

15. How do variations in your routine affect you (mood, medication compliance, self-care, etc.)?

16. In the past year, how many times have you missed school, work, or family events because of your symptoms or treatment?

17. What academic accommodations have been helpful to you in the past?

Handling Crisis

18. Do you experience crisis episodes, including panic/anxiety attacks or psychosis?

- ❑ Yes
- ❑ No

19. How do you recognize when you are in crisis/-need emergency or urgent care? What thoughts or behaviors are clues?

20. During crises, do you typically seek out services yourself or do others recommend additional services?

a. Do you currently have, or have you previously used, a safety plan to help you manage your symptoms?
   - ❑ Yes
   - ❑ No

b. Have you ever encountered legal or disciplinary issues as a result of your mental health challenge? What sanctions or legal consequences, if any, were imposed?
   - ❑ Yes
   - ❑ No

c. Do you currently have, or have you previously used, a behavioral contract to help you manage your behavior?
   - ❑ Yes
   - ❑ No

If yes, please provide details.

Further Information

21. Have you ever had thoughts of harming yourself or someone else?
   - ❑ Yes
   - ❑ No

a. If yes, is this current or how long ago was the last time you had these thoughts?

b. Have you ever made an attempt before?
   - ❑ Yes
   - ❑ No

If yes, when did this happen?

22. Do you self-injure, or have you self-injured in the past?
   - ❑ Yes
   - ❑ No

a. If yes, is this happening currently or how long ago did you self-injure?

23. Have you ever been diagnosed with an eating disorder?
   - ❑ Yes
   - ❑ No

a. If yes, when did you have or do you currently have an eating disorder?

24. Have you ever experienced hallucinations or delusions?

- ❑ Yes
- ❑ No

a. If yes, when did you have or do you currently experience hallucinations or delusions?

Travel

25. How do you typically approach speaking in public or new situations or people?

26. What sources of information have you used to learn about mental health services and cultural attitudes in the host country?

27. Do you have comments, concerns or questions about your travel? Please explain.

Please email this form to the Program Advisor of your intended study abroad program location as soon as