



NAZARETH COLLEGE

Medical History Form Valencia, Spain - Study Abroad Program

Name _____
Last Name First Name Middle Initial

Date of Birth _____ Country of Study _____
DD/MM/YY

Emergency Contact _____ Relationship _____
Phone No. _____

To the Student Applicant:

Nazareth College wishes to provide appropriate assistance to you should the need arise during your study abroad experience. It is important that the program be made aware of any medical or emotional concerns, past or current, which might affect you in a foreign study context. The information you provide will only be shared with the program staff, faculty, or appropriate professionals as it relates to your health and safety.

Instructions:

1. Complete and sign the Medical History Form.
2. Make an appointment with your primary care physician to review this form.
3. Return completed and signed form to the Program Director together with the Valencia Study Abroad Program application packet.
4. If you will be studying abroad for MORE THAN ONE SEMESTER, you will need to obtain a separate medical statement from your doctor on official medical letterhead to include with your student visa application. Please refer to student visa information.
5. Download and print a copy of your immunization information from NazNet and take it with you when you travel.

MEDICAL HISTORY

Name of Primary Care Physician _____ Date of Last Physical _____

List all current medications (including prescription, over the counter, vitamins, herbs, and supplements):

Have you ever been hospitalized or had a major operation? If yes, include date(s) and reasons.

Are you allergic to any medications or substances? Check all that apply.

_____ Aspirin

_____ Penicillin

_____ Acrylics

_____ Latex

_____ Gluten

_____ Pollen

_____ Bees

_____ Other (Explain)

Continues on Back



List all documented disabilities:

Are you on a special diet? If yes, discuss.

Do you have or have you had any of the following diseases or conditions? Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Heart Disease/Surgery | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Heart Murmur or Defect | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> PTSD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Other (Explain) |
| <input type="checkbox"/> Liver Disease | |

I hereby certify that my responses are complete and accurate to the best of my knowledge.

Student Signature _____ **Date** _____

To Be Completed by Primary Care Physician

I have reviewed the above information with the student, and hereby certify that this student is in good physical and mental health to travel to study abroad.

Physician Stamp or Printed Name _____

Physician Signature _____ **Date** _____