NAZARETH COLLEGE

Medical History Form
Florence, Italy - 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 Florence 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)

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NAZARETH COLLEGE

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.

_____ Heart Disease/Surgery
_____ Heart Murmur or Defect
_____ Heart Attack/Failure
_____ High Blood Pressure
_____ Low Blood Pressure
_____ Anemia
_____ Leukemia
_____ Lung Disease
_____ Asthma
_____ Cancer
_____ Stomach/Intestinal Disease
_____ Ulcers
_____ Diabetes
_____ Hypoglycemia
_____ Liver Disease

_____ Hepatitis A
_____ Hepatitis B or C
_____ AIDS/HIV
_____ Stroke
_____ Epilepsy or Seizures
_____ Fainting or Dizziness
_____ Anxiety
_____ PTSD
_____ Depression
_____ ADD/ADHD
_____ Anorexia/Bulimia
_____ Bipolar Disorder
_____ Schizophrenia
_____ Other (Explain)

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** _____