**Instructions to study abroad student:**

Please complete pages 2 and 3.

If you answer “Yes” to any questions, make sure to give details in the space available. If you need more space, please attach another sheet.

**Medical Clearance for Study Abroad Policy:**

An applicant will not be rejected due to either his/her physical or emotional condition unless it is determined that the condition may prevent successful participation in the program, or medical care for an applicant’s medical problem is not available in the country in which the applicant will study, and/or the living and environmental conditions to which the applicant could be exposed would present a health risk to the individual.

A health record is confidential and accessible only to health personnel and the staff of the study abroad office, and the individual program director to which the applicant has applied. For the safety of our students, information regarding an applicant’s health, however, is important in anticipating and managing health problems which may arise during the student’s stay abroad.

**CHANGE OF STATUS**: You are responsible for notifying the Center for International Education immediately of any changes in your health history prior to your departure or while in the program.

**Medical Information Form**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender \_\_\_\_\_

Permanent Address

Street

City State Zip Code *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Cell Phone (\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Name of Study Abroad Program:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. Personal History--to be completed by the student:** Have you ever had or do you now have (circle any conditions you have or had):

* Migraine Headaches
* Seizure Disorder
* Fainting Spells
* Visual Problems
* Hearing Problems
* Chronic Sinus Problems
* Oral problems
* Breast Disease
* Heart Problems
* Irregular or Rapid Heartbeat
* Chest Pain
* High Blood Pressure
* Anemia
* Bleeding Disorders
* History of Blood Clots
* Asthma
* Trouble Breathing
* Chronic or Recurrent Gastrointestinal Problems
* Hepatitis
* Gallbladder Disease
* Pancreatitis
* Kidney Problems
* Diabetes Mellitus
* Endocrine Disorder(s)
* Pre-cancerous or cancer of the reproductive organs
* Sexually Transmitted Infection
* Chronic Skin Problems
* Chicken Pox
* Infectious Mononucleosis
* Tuberculosis or contact with Tuberculosis
* Malaria
* Anxiety
* Depression
* Attention Deficit Disorder
* Bipolar Disorder
* Eating Disorder
* History of Suicide Attempt
* Significant Allergic Reaction(s)
* Serious Accident(s)

Physical Disability (please elaborate):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medications:

List all medication allergies (if none write ‘none” in space): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all environmental allergies (ie: bees, pollen, etc)

Do you have any dietary restrictions or food allergies? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give details of those items circled using the back of this page and adding additional sheets if necessary. Indicate problem, diagnosis if known, and whether recovery has been complete or if still under treatment.

**III. Current Medical History**

Have you been in good health during the past 12 months?

Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Do you have any medical conditions requiring on-going medical supervision and treatment, or have you had in the past any significant condition which is

currently in remission? (Ex. diabetes, heart problems, chronic or recurrent gastrointestinal disorder, seizure disorder, cancer, bleeding disorder, etc.) Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Are you currently receiving, or have you received in the past two years, counseling for *any* emotional problem, drug addiction, alcoholism, psychiatric condition

or eating disorder? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

**I certify that I have read and understand the Medical Clearance for Study Abroad Policy, and that all responses made on this Medical Information Form are true and accurate, and that I will notify the study abroad office hereafter of any relevant changes in my health that occur prior to the start of the program. I also understand that information on this form may be shared between the Study Abroad Office, my Program Director, and Health Personnel of Student Health & Counseling Services, in order to determine medical clearance for participation in study abroad.**

**Signature of Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

**For office use only:**

**\_\_\_\_\_\_\_Medically cleared for study abroad**

**\_\_\_\_\_\_\_Medically cleared for study abroad with the following recommendations:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_Unable to medically clear student**

**Examining Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License #: \_\_\_\_\_\_\_\_\_\_\_\_**

Name (Printed)

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**