MEDICAL REPORT FORM FOR STUDY ABROAD PROGRAMS

INSTRUCTIONS TO PROGRAM PARTICIPANT:
Please print legibly or type the information requested below. Your physician is requested to complete the remainder of the Medical Report and return it to you. Please ensure that the information on the Medical Report is complete and accurate, and return the Medical Report to the **College's WCCCSA Coordinator at least 4 weeks prior to your departure**. ALL INFORMATION PROVIDED ON THIS MEDICAL REPORT IS CONFIDENTIAL AND WILL NOT BE RELEASED EXCEPT AS AUTHORIZED BY THE PARTICIPANT, BELOW.

Full Name: _____

❑Male ❑Female Birth Date_____/_____/_____

U.S. Mailing Address: _____

Height: _____Weight: _____ Country(ies) of travel: _____

List any allergies: _____

List any medications you are taking: _____

If on a restricted diet, please describe: _____

Have you ever been treated by a mental health professional or counselor for any mental, emotional, or nervous disorder or illness or addiction in the past five years? ❑**YES** ❑**NO**

If YES, please provide a brief description here: _____

_____

_____

Give all documentation pertaining to the mental illness/disorder to the physician completing this Medical Report. Your mental health professional's report will be kept confidential and will NOT be submitted to the College.

EMERGENCY CONTACT: _____ Relationship: _____

Mailing Address: _____

Tel: _____ E-mail: _____

RELEASE TO BE SIGNED BY PARTICIPANT
I hereby authorize and consent to the release of the information in this Medical Report to the Study Abroad Office of Highline Community College and to the coordinator(s) of my study abroad program, including any information about my health status with respect to HIV/AIDS, sexually transmitted disease(s), mental illness and/or substance abuse on a need-to-know basis as determined by a health care professional in order to safeguard my health, safety, and welfare as well as that of the program participants during the course of my program abroad.

Signed: _____ Date: _____

"The information provided on this Medical Report is true and correct to the best of my knowledge, and I will take full responsibility for participating in a comprehensive health examination as well as undergoing all required vaccinations and immunizations in preparation for my study abroad program."

Participant's signature: _____ Date: _____

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INSTRUCTIONS TO THE PHYSICIAN COMPLETING THIS MEDICAL REPORT:
Thank you for evaluating the physical and mental health of the above-named study abroad program participant. Depending upon the program, participants spend anywhere from 4 weeks to 3 months abroad. It is extremely important that all participants be able to adjust to the dramatic changes in climate, diet, and living conditions. Living overseas can also create emotional and physical stress for participants; in some cases, mild disorders can become serious under the stress of life in unfamiliar surroundings. Participants live in homes with local families or in apartments with other student travelers; participants may live and study in a situation which offers few amenities and little privacy. A participant will not be removed from a program due to either a physical or emotional condition unless it is of such a serious nature that the participant becomes a danger to himself/herself or a danger to others. It is essential that this Medical Report be based on a current and thorough physical examination and knowledge of the participant's medical history. Information in this Medical Report will be shared with relevant parties only under the authorization of the participant. Please return this Report to the participant upon completion of your examination. Thank you.

How long have you been the participant's physician?* : _____
*REPORTS PREPARED BY PARENT-PHYSICIANS ARE NOT ACCEPTED

Date of last medical examination/treatment: _____

Participant's general state of health is: ❑Good ❑Fair ❑Poor

Is the participant or does the participant have:

1. Seriously ❑underweight or ❑overweight? ❑YES ❑NO
2. Allergic to any medication? ❑YES ❑NO
3. Significant speech, hearing, or eyesight impairment? ❑YES ❑NO
4. Any physical disability that might result in severe hardship due to change in diet, carrying luggage/parcels, climate change, or strenuous travel? ❑YES ❑NO

5. Please identify any congenital malformation now existing that may require additional treatment and your medical recommendation for treatment below: ❑YES ❑NONE

6. Has participant ever suffered from asthma or other respiratory ailment? ❑YES ❑NO

7. Has the participant any infectious or contagious disease? ❑YES ❑NO

8. Has the participant ever had an eating disorder? ❑YES ❑NO

9. Is participant currently under treatment or observation for any physical or emotional condition? ❑YES ❑NO

10. Is there any history of emotional disturbance in the participant? For example, unusual difficulties in relations with authority figures or peers, significant mood swings, depression, severe sleep disorder, severe anxieties, fear, or guilt. ❑YES ❑NO

11. To your knowledge, are there any predisposing/preexisting medical, surgical, or emotional factors which may, under stress or duress encountered during the program, present a need for immediate therapy while abroad? ❑YES ❑NO

IF THE ANSWER TO ANY OF THE QUESTIONS ABOVE IS YES, PLEASE ELABORATE IN THE SPACE PROVIDED BELOW, REFERRING TO THE QUESTION ABOVE BY ITS NUMBER.

Print Physician's name | Physician's signature | Date

Office mailing address

Telephone | Fax