MEDICAL EXAMINATION FORM FOR STUDY ABROAD PROGRAMS

INSTRUCTIONS TO PROGRAM PARTICIPANT:
Have this form completed by a licensed physician and return it to the **College's Study Abroad Coordinator at least 8 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: _____ Birth Date_____/_____/_____

Study Abroad program location and length of stay: _____

RELEASE TO BE SIGNED BY PARTICIPANT
I hereby authorize and consent to the release of the information in this Medical Examination Form to the Study Abroad Office at my 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: _____

Please note:

- If a doctor is unwilling/unable to prescribe medication in sufficient quantities for the length of the program, students should plan ahead for a postal delivery or make other arrangements. However, please be aware that in many European countries it is not possible to send prescription medications through the mail and packages will not be delivered.
- WCCCCSA highly recommends that students take medical advice about the side effects that flying, temperature changes, different foods and alcohol may have on their reaction to medications.
- If a student has a disability that requires a special "accommodation" or special conditions, he/she should request information about the specific study abroad program in advance. Some study abroad locations may not have handicap access like that which is available and expected in the U.S.
- If a student does not submit a medical form prior to departure he/she will not be permitted to participate in the program.

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INSTRUCTIONS TO THE PHYSICIAN COMPLETING THIS MEDICAL EXAMINATION FORM:
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 2 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. <u>It is essential that this Medical Form be based on a current and thorough physical examination and knowledge of the</u>

participant's medical history. Information in this Medical Form 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

A. To the best of your knowledge and belief, has the participant ever had, been treated for, or told that she/he had:

	YES	NO
1. Heart disease, high blood pressure, varicose veins or disease of the circulatory system	❑	❑
2. Diabetes, goiter or any disease of the glands	❑	❑
3. Epilepsy, fainting attacks, or other disease of the brain or nervous system	❑	❑
4. Fistula, fissure, hemorrhoids or other disease of the rectum	❑	❑
5. Cancer or tumor, syphilis or tuberculosis	❑	❑
6. Asthma, pleurisy, or other disease of the respiratory tract	❑	❑
7. Neck or back strain or injury or hernia	❑	❑
8. Any deformity or loss of limb	❑	❑
9. Any disease of the reproductive organs	❑	❑
10. Schizophrenia or any mental disorder	❑	❑
11. Manic depression or depression	❑	❑
12. Anorexia and/or bulimia	❑	❑
13. Ulcer or any disease of the stomach, intestines, liver, gall bladder or other disease of the gastrointestinal tract	❑	❑
14. Sugar in urine, kidney disease, or other disease of the genitourinary tract	❑	❑
15. Arthritis, rheumatism, or other disease of the bones	❑	❑
16. Any impairment of sight, speech or hearing, or any disease of the eye, ear, nose or throat	❑	❑
17. Any surgical operation performed or been advised to have any performed during the past five years	❑	❑
18. Any substance abuse	❑	❑
19. Allergic reactions to food, environment or drugs	❑	❑
20. Any special dietary needs, preferences or difficulties	❑	❑
21. Any menstrual problems including irregular/painful periods and pre-menstrual syndrome	❑	❑
22. Any other illnesses, diseases or treatments not mentioned above during the past three years	❑	❑

Question #	Name of condition	Date occurred	Duration	Degree of recovery	Names and addresses of physicians, hospitals or clinics consulted

Give details to all "yes" answers. If more space is needed, attach separate sheet

B. Is the applicant presently using any kind of prescribed medication? ❑ yes ❑ no
If yes, please list all medications (both prescription brand and generic name) applicant is currently taking and the medical condition _____

_____

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C. To your knowledge, are there any predisposing/preexisting medical, surgical, or emotional factors that may either restrict the applicant from participating in essential functions of studying abroad or require accommodations in order to successfully participate in the program? ❑ yes ❑ no
If yes, please give details _____

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_____

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"I have carefully examined and find said person in sound health and free from all physical defects and infirmities, except as stated."

_____ _____ _____
Print Physician's name Physician's signature Date

_____
Office mailing address

_____ _____
Telephone Fax

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"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: _____