PARTICIPANT MEDICAL FORM FOR STUDY ABROAD

INSTRUCTIONS TO PROGRAM PARTICIPANT:
Please print legibly or type the information requested below. Your physician is requested to complete the Medical Examination Form and return it to you. Please ensure that the information on the Medical Examination Form is complete and accurate, and return all medical forms 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 (as on passport): ______________________________

Preferred Name: ____________________ Country(ies) of travel: ____________________

Birth Date______/______/______ ○ Male ○ Female ○ Transgender/Gender Non-conforming

U.S. Mailing Address: ______________________________

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 your Medical Examination Form. 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: ____________________

"I hereby authorize and consent to the release of the information in this Participant Medical Form to the Study Abroad Office at my college, and to the coordinator(s) of my study abroad program in order to safeguard my health, safety, and welfare as well as that of the program participants during the course of my program abroad.
The information provided on this Participant Medical Form 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: ______________