In the event that I am unable to give consent to medical care myself in the case of a life-threatening emergency, and/or if my parents/guardians cannot be reached, I hereby give to the faculty director, onsite coordinator or a duly appointed representative consent to care for me, including medical and surgical treatment and hospitalization if necessary. Further, I attest that I have fully and honestly disclosed all/any medical or emotional conditions for which I am currently being treated or was treated in the past. If any new issues arise after filling out this medical form, I will let the CGE know.

Your signature __________________________ Date ______________________

For participants under 18 years of age:
I give permission for the faculty director(s) or his/her representative to obtain and consent to care for my son/daughter, including medical and surgical treatment and hospitalization if necessary, in the event that I cannot be reached in an emergency.

Signature of parent/guardian: __________________________ Date: ______________________

1. GENERAL INFORMATION
Name: __________________________________________________  Sex:  ____  Birth Date: _____/_____/_____
Campus Address: __________________________________________________ Phone: ________________
Parent/Guardian Name: _______________________________________________ Phone: ________________
Address: _____________________________________________________________ Cell Phone: _____________
Emergency Contact:
Name: _______________________________________________________________ Phone: ________________
Cell Phone: ______________
Address: ____________________________________________________________ Relation: _______________

II. CURRENT MEDICAL HISTORY

a. Do you have any significant chronic medical conditions requiring on-going medical supervision and treatment, or have you had in the past any significant chronic medical conditions which are currently in remission? (for example: ADD, ADHD, diabetes mellitus, heart problems, chronic or recurrent gastrointestinal disorders, seizure disorders, treatment for cancer, bleeding disorders, etc.)

   *Yes ___  No ___

b. Do you suffer from anxiety, depression, an eating disorder, alcohol or drug addiction or any other psychiatric condition? If yes, are you currently receiving, or have you sought in the past two years, counseling or treatment for any of these issues?

   *Yes ___  No ___

*If you answered “yes” to A or B above, please give details:
(note: if you are currently receiving treatment for this medical/psychiatric issue, you should also have that doctor fill out a copy of the physician’s page at the end of this form in addition to your general practitioner, unless your general practitioner is fully aware of and can comment on the progress of that condition).

________________________________________________________________________________
________________________________________________________________________________


III. PAST MEDICAL HISTORY

   Yes  No

a. Have you been hospitalized during the past year?  ____  ____
b. Have you been hospitalized previously?  ____  ____
c. Have you had an operation during the past year?  ____  ____  Yes  No
d. Have you had an operation previously? _____ _____
e. Have you ever been told by a physician to avoid strenuous activity? _____ _____
f. Have you ever had migraine headaches? _____ _____
g. Have you ever suspected or been told that you might have an eating disorder such as anorexia nervosa or bulimia? _____ _____
h. Have you ever had TB or been exposed to anyone with tuberculosis? _____ _____
i. Have you had a skin test for tuberculosis?
   If yes, please give date: ______________________________________________________
j. Was the skin test positive? _____ _____
k. Have you ever had an allergic reaction to any medication?
   If yes, please list: ___________________________________________________________
l. Do you have any allergies besides those listed in k above?
   If yes, please list, describing the severity and symptoms associated with this allergy:
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
m. Do you have any orthopedic problems that restrict physical activity? _____ _____
n. Have you ever suspected or been told that you have an alcohol or drug addiction problem? _____ _____
o. Do you have diabetes mellitus?
   Has your condition been stable over the past two years? _____ _____
   Please list medications in Section IV.
p. Do you have a seizure disorder?
   Have you had a seizure in the past two years? _____ _____
   If yes, please list date(s): ___________________________________________________
   Please list medications in Section IV.
q. Do you have any dietary restrictions?
   Please list in Section IV.
r. Do you tend to experience motion sickness due to travel by car/bus; boat/ship; airplane?
   (circle the types of transport that tend to cause sickness) _____ _____
s. Describe your swimming skills: Poor Fair Good Expert
   Please list special safety skills you may possess such as EMT, CPR, First Aid, Lifeguard Certification:
t. Have you had any of the conditions listed below? Please give date and describe treatment, if any, in section IV.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anemia</td>
<td></td>
<td></td>
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<tr>
<td>2. Asthma</td>
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<tr>
<td>3. Heart murmur</td>
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<td>4. Heart palpitation</td>
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<td>5. Rheumatic fever</td>
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<td>6. High blood pressure</td>
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<td>7. Hepatitis</td>
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<td>8. Mononucleosis</td>
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<td></td>
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<tr>
<td>9. Kidney infection</td>
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<tr>
<td>10. Other kidney disease</td>
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<tr>
<td>11. Chickenpox</td>
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<td>12. Measles</td>
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<tr>
<td>13. Mumps</td>
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<td>14. German measles</td>
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<tr>
<td>15. Malaria</td>
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</tbody>
</table>

u. Is there other information we should know about your medical history or need for special services or support while you are abroad?

IV. PLEASE GIVE A SHORT EXPLANATION FOR EACH "YES" ANSWER IN SECTION III.
For example, if you were hospitalized within the past year, indicate the problem, the diagnosis if you know, if recovery has been complete, or if you are still under treatment. If you are still under treatment, your physician must complete Section VI.

IV B. Please list any prescription medications you are taking:

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Condition it is prescribed for</th>
<th>Dosage (if known)</th>
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V. IMMUNIZATIONS
This information should be obtainable from your physician.

<table>
<thead>
<tr>
<th></th>
<th>Date completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Polio Sabin series</td>
<td></td>
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<tr>
<td>b. DPT</td>
<td></td>
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<tr>
<td>c. DPT booster within the past ten years</td>
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<tr>
<td>d. Measles</td>
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<tr>
<td>e. Mumps</td>
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<tr>
<td>f. Rubella immunization or rubella titer</td>
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<td>g. Menomune</td>
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</tbody>
</table>
This student has been admitted to an academically challenging study abroad program in Queensland, Australia. **You are being asked to evaluate the physical and mental health of the above named student for safe participation abroad.** Living in unfamiliar surroundings such as those encountered by living abroad can create emotional and physical stresses that may exacerbate mild disorders.

Students who are studying in **Queensland, Australia** will often have access to a high level of medical care with modern medical facilities. Even with good access to care, however, culture shock, differences in diet, different cultural mores regarding alcohol and drug use may lead to exaggerated health problems.

At times, however, this program will take students to remote areas exposed to harsh environmental conditions with poor or limited water supply and away from immediate, full-service medical care. The ecosystems to which students will be exposed include desert, tropical rain forest, high (altitude) volcanic regions, and remote marine islands. Gastrointestinal problems may occur. Sun poisoning or disorders from overexposure to sun is not uncommon if students do not exercise appropriate precautions. Individuals with certain medical conditions which can lead to electrolyte imbalance such as inflammatory bowel disease, diabetes mellitus and insipidus, as well as individuals on Lithium, would be at greater risk, as would persons with unstable seizure disorders, problem asthmatic patients, and individuals with cardiac disorders. Supervision of psychiatric conditions is not practical in many of these locations.

**The physical challenges of this program are considerable.** Students may need to walk up to 10 miles a day with a full pack, ascending altitudes as high as 2500 feet in one day. **Climbing, diving and carrying will be required.** In some cases, it may be possible for a student to remain behind if the demands of a particular site are too challenging for his/her condition. In these cases, provisions will be made for the student to complete an alternate assignment at a more suitable site where more extensive care is available.

Finally, MANY countries throughout the world limit or ban certain psychotropic drugs from entering their borders. If a psychotropic drug which is commonly used to treat conditions such as ADD, depression, bi-polar or obsessive-compulsive disorders is prescribed, please check whether this drug is permitted in the country for which the student is destined and that the quantity prescribed meets guidelines permitted by customs regulations.

If additional space is required, please attach report.

(Physician’s/Health Provider’s evaluation continued)

Diagnosis:

Medications and dosages:

Special diet or dietary restrictions:

Stability of condition over past two years:
Student’s name: _________________  Program: Queensland, Australia

Recommendations for the care of this individual:

Is this individual capable of participating in the above named study abroad program?  Yes _____  No _____

If yes, are there particular activities or environments from which the student should be restricted?  (describe)

Signature of physician or health care provider: ______________________________________________________

Name of provider (printed): ______________________________________________________________________

Address/telephone: ____________________________________________________________________________

RETURN OF FORM:  Please return this form to International Programs/Old Chapel – 3rd Floor, 807 Union Street, Schenectady, NY 12308 or fax to: (518) 388-7124