HOBART AND WILLIAM SMITH COLLEGES/UNION COLLEGE
MEDICAL REPORT FOR STUDY ABROAD

Your name: _____ Program and semester you will be abroad: _____

INSTRUCTIONS TO THE APPLICANT: Complete Sections I through V. If you respond "YES" to any of the questions in Section III, please elaborate on these in Section IV. At the bottom of Section V, please sign and date the form, verifying that the information given is correct.

A visit to your physician is required unless you've had a physical within the past 12 months. Even in this case, the physician coordinating your care must fill out Section VI before this form will be considered complete. **Note that Hubbs cannot do study abroad physicals and are not able to complete this form**, except in exceptional circumstances, such as an international student who will not be returning to their home country and will thus not have access to their home doctor for a physical.

After obtaining the physician's evaluation/signature in Section VI, RETURN THE FORM to:

International Programs Office
Union College
807 Union Street
Schenectady, NY 12308

MEDICAL REPORT REVIEW: This medical report is subject to review by the HWS and/or Union faculty director(s) for your program and the HWS study abroad administrator and the Director of the campus health center. An applicant will not be prohibited from participation abroad on the basis of either a physical or emotional condition unless it is of such a serious nature or degree as to prevent successful participation in the program; medical care for an individual's medical problem is not available in the program area; and/or the living and environmental conditions to which the applicant could be exposed would present a serious risk to the health of the individual.

I, _____, give permission for this form to be kept on file with
Please print name
the Center for Global Education (CGE) and with the faculty directors or onsite coordinators of my program, and for the form to be provided to health care personnel in the event that I require medical care during my semester off campus. 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 physical and/or mental health conditions that affect me or have affected me in the past, whether I have sought treatment for them or not. I understand that if I fail to disclose any physical and/or mental health conditions that later impact me or others during my semester abroad, I may be dismissed from the program.*** *If any new issues arise after filling out this medical form, I will let the CGE know as soon as possible and* ***before*** *I depart for my program country.*

_____ _____
Your signature Date

ONLY 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: _____

I. GENERAL INFORMATION

Name: _____ Sex: ____ Birth Date: _____/_____/_____

Campus Address: _____ Phone: _____

Emergency Contact

Parent/Guardian Name: _____ Phone: _____

Address: _____ Cell Phone: _____

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? *Yes ☐ No ☐

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).

_____

_____

_____

c. Do you have any disability or academic accommodation which will require accommodation abroad? Yes ☐ No ☐ If yes, please describe

_____

_____

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?	☐	☐
d. Have you had an operation previously?	☐	☐
e. Have you ever been told by a physician to avoid strenuous activity?	☐	☐

	Yes	No
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.

	Yes	No		Yes	No
1. Anemia	☐	☐	9. Kidney infection	☐	☐
2. Asthma	☐	☐	10. Other kidney disease	☐	☐
3. Heart murmur	☐	☐	11. Chickenpox	☐	☐
4. Heart palpitation	☐	☐	12. Measles	☐	☐
5. Rheumatic fever	☐	☐	13. Mumps	☐	☐
6. High blood pressure	☐	☐	14. German measles	☐	☐
7. Hepatitis	☐	☐	15. Malaria	☐	☐
8. Mononucleosis	☐	☐			

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

IV. A. 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 comment on this under Section VI.

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

Name of medication	Condition it is prescribed for	Dosage (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

V. IMMUNIZATIONS

This information should be obtainable from your physician.

	Date completed
a. Polio Sabin series	_____
b. DPT	_____
c. DPT booster within the past ten years	_____
d. Measles	_____
e. Mumps	_____
f. Rubella immunization or rubella titer	_____
g. Menomune	_____

Student Name: _____ Program Location: _____

VI. TO BE COMPLETED BY PHYSICIAN

This student has been admitted to an academically challenging study abroad program. **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 Europe, New Zealand and Japan will have consistent access to a high level of medical care (although in some cases the individual providing emergency care will not be an English-speaker) with modern medical facilities. Even in these areas, however, culture shock, differences in diet, different cultural mores regarding alcohol and drug use may lead to exaggerated health problems. (In addition, most students studying abroad find that they are expected to walk greater distances, often carrying groceries or full book bags, than they might be accustomed to in the United States.)

Students who are studying in Latin America, Vietnam, China, and Africa may, at times, be in remote areas exposed to harsh environmental conditions with poor or limited water supply and away from immediate, full-service medical care. Gastrointestinal problems are relatively common. Individuals with certain medical conditions which can lead to electrolyte imbalance such as inflammatory bowel disease, diabetes mellitus and insipidis, 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.

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 their guidelines.

If additional space is required, please attach report.

Diagnosis:

Medications and dosages:

Special diet or dietary restrictions:

Stability of condition over past two years:

Recommendations for the care of this individual:

Is this individual capable of participating in the above named study abroad program? Yes ____ No____

Signature of physician or health care provider: _____

Name of provider (printed): _____

Address/telephone: _____

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