Short-term Travel Abroad Medical Report

The purpose of this form is to determine your health history and any special needs you may have when you travel abroad. Information provided will be treated confidentially. Any information considered important and essential will be forwarded to trip leaders for the purpose of serving you as promptly and correctly as possible should you require medical or counseling services during your time abroad.

Participant Last Name_____ First Name _____
Health Insurance Company_____ Policy Number _____
Company Address_____ City _____ State_____ Zip _____
Telephone _____

Emergency Contact:
Name_____ Relationship to participant _____
Home phone _____ Work phone _____
Cell phone _____ Email _____

Have you had or do you currently have any of the following conditions? If yes, please detail information in the space provided below and includes dates if it was a past condition. Attach additional sheets if necessary.

	Yes	No	If yes, please explain
Alcohol/Drug Addiction	_____	_____	_____
Asthma	_____	_____	_____
Cancer	_____	_____	_____
Chronic Condition	_____	_____	_____
Diabetes	_____	_____	_____
Eating Disorder	_____	_____	_____
Emotional Disorder	_____	_____	_____
Epilepsy/Seizure Disorder	_____	_____	_____
Frequent Trouble Sleeping	_____	_____	_____
Heart Condition	_____	_____	_____
Heart Disease	_____	_____	_____
Hypoglycemia	_____	_____	_____
Painful shoulder, knee or back	_____	_____	_____
Thyroid Condition	_____	_____	_____
Other:	_____	_____	_____

Do you have any allergies (i.e.: food, medicine, etc,)? YES____ NO____
If yes, please describe the allergy source _____
What are your symptoms/reactions to the allergy? _____
Is it life threatening? YES____ NO____ **Any other food restrictions?** _____
Have you had any injuries, which have required hospital/ER attention? (i.e.: major accident, etc.) YES____ NO____
If yes, when and what for? _____
Have you ever been hospitalized? YES____ NO____ If yes, when and what for? _____
Have you had any surgical procedures? YES____ NO____ If yes, when and what for? _____
What is your condition as a result of the surgery? _____
Are you currently taking medications? YES____ NO____ If yes, which medications and for what? _____
_____
Have you ever been treated for any psychological/emotional problems? YES____ NO____ If yes, list dates: _____
If yes, please describe the nature of the problem: _____
_____
Did or does your treatment require medication? YES____ NO____ If yes, please list medications _____
_____
Current Status: _____

PLEASE NOTE: The following questions address disability-related needs of participants. Provision of the following information is voluntary.
Do you have a documented disability as defined by the Americans with Disabilities Act? YES____ NO____
If yes, please state the nature of the disability: _____
In which areas does your disability currently impair your ability to perform daily academic activities? _____
_____
Are you requesting any academic activity accommodations for the above listed disability? YES____ NO____
If yes, please separately provide documentation from a qualified professional that speaks to your current needs for accommodation.

If there is any additional health information that would be helpful for the trip leaders to be aware of during the study trip, please describe on the back of this form.

I testify that the information provided above is true, accurate and to the best of my knowledge.

Participant signature: _____ Date: _____

Parent signature if under age of 18: _____