**ALL TRAVELERS**

**STUDY ABROAD/TRIP
MEDICAL INFORMATION FORM**

(Please print legibly)

**Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Middle Last**

Gender (circle one) F M

Date of birth (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Do you have any physical or emotional limitations which might cause hardship in travel,

change of location, or field work? Yes No *If yes, please explain*.

2. Do you have any dietary, allergic, or other medical conditions which could require special medical attention? Yes No

 *If yes, please explain.*

3. To your knowledge, do you have any predisposition towards a medical or emotional condition which may, under stress or duress during a study/travel course, present a need for immediate

 intervention therapy? Yes No

 *If yes, please explain.*

4. Please list any serious illnesses you have had in the past three years.

5. Do you have any special needs or accommodations while on trip abroad? Yes No

*If yes, please explain.*

6. Please list any medications to which you know you are **allergic**:

7. Current medications and the conditions for which they were prescribed:

8. Will you need any assistance in taking the above medications while on the trip abroad? Yes No *If yes, please explain*.

**Do you:**

9. Smoke? Yes No

10. Wear contact lenses? Yes No

11. Have an orthodontic device? Yes No

12. Have removable false teeth? Yes No

13. Your Physician:

Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

14. Current Health Insurance Provider

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby affirm that all information supplied on this form is true and accurate, and that I accept responsibility for any financial losses to the College which might result from my failure to disclose relevant medical information.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant Date