



## Medical Form

This form consists of two sections. The first should be filled out by the student and the second by the student's physician. The information provided will be held in strict confidence and only used when needed for medical care. Complete and correct information will ensure proper care and treatment for participants while on their study abroad program.

*Please type or print clearly using blue or black ink.*

### Section I: To be filled out by the student

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Program and Program Dates:

\_\_\_\_\_

Are you currently under a physician's care for any reason? If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

If not, when did you last visit a physician and for what reason?

\_\_\_\_\_

Are you currently taking any medications?

Please provide the following information for each medication that you are currently taking either regularly or on an as-needed basis: *(We recommend that you bring a sufficient supply of these medications with you along with a physician's prescription to justify them. Divide them between your checked and carry-on luggage.) Attach a separate sheet if necessary.*

Commercial name    Scientific/generic name    Dosage/frequency    Date prescribed

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Please list any allergies and/or special dietary needs that you suffer from and the treatment you take for them, if any.

If you have serious allergies and/or special dietary needs, please note you are responsible for monitoring your own environment, intake and exposure, and providing your own treatment if/when necessary. SAOA is not responsible for the arrangement, fulfillment or provision of special dietary needs. Please describe here and include on your housing application:

\_\_\_\_\_

\_\_\_\_\_

Do you have or have you had any eating concerns or issues during the last 24 (twenty-four) months?

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Do you have any dietary restrictions? If so, please explain.

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Have you been hospitalized in the last 3 years? If so, for what reason?

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Have you had any diseases or injuries in the last 3 years? If so, please describe briefly:

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Are you currently, or have you ever been, under the care of a mental health specialist of any kind (psychoanalyst, psychiatrist or psychologist)? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever sought or are you currently in treatment for a mental, psychological, substance abuse or emotional condition? \_\_\_\_\_ Yes \_\_\_\_\_ No.

If you answered yes, please attach a brief explanation or report from your therapist. Make sure to include any medications you are currently taking. This information will be kept strictly confidential.

Are you currently or on an ongoing basis experiencing any seriously negative feelings (such as high anxiety, continuous sleeplessness, grief, nightmares, high stress, depression, etc.)?

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Do you have any condition/s or participate in religious observations which may require special assistance or accommodation while abroad, or which may keep you from participating in certain activities?

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Is there any other medical-related information that you feel we should be aware of or have on hand to help ensure proper medical attention while you are on the SAOA program? If so, please describe below:

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**Emergency Contact Information (Must be completed)**

Name of person to contact in case of emergency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone numbers: \_\_\_\_\_ E-mail: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

I hereby certify that the information I have provided on this sheet is complete and accurate to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Medical Form - Section II. To be filled out by a physician.** *(Please print or write clearly.)*

The student named below has been admitted to a study abroad program in Spain. The information you provide will help us ensure that adequate medical care is provided when needed. All information will be held in strict confidence and used only when necessary to determine correct medical assistance.

*Please print clearly all information provided. Thank you.*

Student's name: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's phone or e-mail: \_\_\_\_\_

Are you this student's regular physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how long has this student been a patient of yours? \_\_\_\_\_

If no, please explain the circumstances under which you are filling out this form.

\_\_\_\_\_

\_\_\_\_\_

Date of physical examination: \_\_\_\_\_

Student's current health status based on examination:

\_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Does the student have any allergies?

\_\_\_\_\_

Does the student have any health problems that need to be monitored while abroad?

\_\_\_\_\_

\_\_\_\_\_

Please review the list of medications the student has included in Section I of this form. Is this list complete and correct to the best of your knowledge?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Please include any clarifications, modifications, instructions or precautions you feel would be helpful as regards this student's medications:

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Does the student have any history of emotional disturbances, mental illness or stress-related disorders, including eating disorders? If so, please include a brief description of time, type, severity, treatment.

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Please describe any special circumstance regarding this student's health that you feel we should know about.

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Is there any medical reason why you feel it would not be advisable for this student to participate on a study abroad program?

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Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your assistance.