

Medical Information Form

General and Emergency Contact Information

Name: _____ Student ID (or SSN): _____

Country of Study: _____ Program: _____

Gender: _____ Height: _____ Weight: _____

Physician's Contact Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Person to notify in case of an emergency:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Tel.: _____ Bus. Tel.: _____ Cell: _____

Medical History

If you answer "yes" to any of the following questions, you must complete and return the Physician's Report form on the last page. Please contact us if any conditions or treatments significantly change before the start of your program or while you are abroad.

Are you currently under medical treatment? __ yes __ no

Do you have any ongoing or chronic medical condition (asthma, diabetes, etc.)? __ yes __ no

Please identify the condition or conditions:

Medical History (continued)

Are you currently taking any medications? yes no If yes, please list name, dosage, prescribing physician and, if not listed above, contact information for that physician. Use an additional sheet of paper if you need more space. Please return the Physician's Report form on the last page if you are taking prescriptions for a serious medical condition or for depression, anxiety, or other psychological condition. (You do not need to return the form on the last page if you are taking routine prescriptions such as birth control, skin care or allergies.)

Name of medication	Dosage	Physician Information
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What condition(s) is (are) being treated with the above medication?

Are you taking the medication(s) on a temporary or on-going basis?

Please list any dietary restrictions or preferences:

Please list any allergies to medication, food or other substances/conditions:

Medical History (continued)

Have you had any psychological or emotional problems (including eating disorders and substance abuse) during the past five (5) years for which you have sought professional medical attention? yes no

If yes, please describe and indicate whether you are taking medication for that condition and return the Physician's Report form on the last page.

Do you have any conditions (including physical impairments or learning disabilities) that might restrict your mobility or require special facilities or assistance while abroad? yes no

Have you had any diseases, surgical operations or significant injuries within the last five (5) years that could have an effect on your participation in this program? yes no
If yes, please explain and return the Physician's Report form on the last page.

Have any surgical operations been recommended that could have an effect on your participation in this program? yes no If yes, please explain and return the form on the last page.

Is there anything else about your health or medical history that may be a factor should there be an emergency? yes no If yes, please explain:

Authorization Statement

I hereby authorize Illinois Wesleyan University to release information from my medical history, including but not limited to medical records, upon the request of the International Office. I further authorize the release of information by the International Office to the relevant program director and to the cooperating or affiliated foreign institutions.

I understand that the International Office will not request any information from my medical records unless a situation arises while I am studying abroad that requires information pertinent to my safety or health. I further understand that any information obtained from of my medical records that held by the International Office will be destroyed upon the completion of my study abroad program.

I understand that, if I have a medical condition that requires or has required treatment, I must discuss my plan to study abroad with my clinician.

I certify that the information on this Medical Information Form is true and correct, and I will notify the International Office hereafter of any significant or relevant changes in my health that occur prior to or during the study abroad program.

Student's Signature: _____

Printed Name: _____ Date: _____

Physician's Report

(This form is required only if directed by responses earlier in the questionnaire)

_____ (print student's name) has identified a chronic and/or recurrent health issue. Please evaluate the physical and/or mental health of this student, who intends to participate in a study abroad program in _____ (print foreign location). The availability of medical services in the country (or countries) and areas within which the student will be living and traveling should be considered.

Diagnosis:

Medications and dosage:

Stability of condition over the past five (5) years:

To your knowledge, are there any predisposing medical, physical, or emotional factors that, under stress of adjusting to life in another country, may require treatment while the student is abroad?

Recommendations for care of this individual:

Physician's Signature: _____

Printed Name of Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Please complete and return to: International Office, Illinois Wesleyan University, P.O. Box 2900, Bloomington, IL 61702-2900; fax: 309-556-3727.