

**HOBART AND WILLIAM SMITH COLLEGES/UNION COLLEGE  
MEDICAL REPORT FOR STUDY IN AUSTRALIA**

**Your name:** \_\_\_\_\_ **Semester going 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 6 months and your physician feels s/he can respond to this form based upon your records. In all cases, the physician coordinating your care must fill out Section VI before this form will be considered complete.

After obtaining the physician's/provider's evaluation in Section VI, RETURN THE FORM by June 1<sup>st</sup> (for Fall departures) or September 1<sup>st</sup> (for Spring departures) to:

Center for Global Education  
Trinity Hall 3<sup>rd</sup> Floor  
Hobart and William Smith Colleges  
Geneva, NY 14456

MEDICAL REPORT REVIEW: This medical report is subject to review by the HWS and/or Union College faculty director(s) for your program, the HWS/Union study abroad administrators and the Director of your 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 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/any medical or emotional conditions for which I am currently being treated or was treated in the past.*

\_\_\_\_\_  
Your signature

\_\_\_\_\_  
Date

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**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: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

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

II. CURRENT MEDICAL HISTORY

a. Have you 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: diabetes mellitus, heart problems, chronic or recurrent gastrointestinal disorders, seizure disorders treatment for cancer, bleeding disorders, etc.) \*Yes \_\_\_ No \_\_\_

b. Are you currently receiving, or have you received in the past two years, counseling in the treatment of any emotional problem, drug addiction, alcohol problem, psychiatric condition, or eating disorder? \*Yes \_\_\_ No \_\_\_

c. Do you have any handicap or disability which will require accommodation abroad? (Include academic accommodations) 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?<br>(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:

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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. 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 complete Section VI.

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 \_\_\_\_\_

VI. TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROVIDER

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

**Program:** Australia and New Zealand

This student has been admitted to an academically challenging study abroad program in Australia and New Zealand. **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 Australia/ New Zealand will often have access to a high level of medical care with modern medical facilities. Even with good access to care, however, culture shock, differences in diet, different cultural mores regarding alcohol and drug use may lead to exaggerated health problems.

At times, however, this program will take students to remote areas exposed to harsh environmental conditions with poor or limited water supply and away from immediate, full-service medical care. The ecosystems to which students will be exposed include desert, tropical rain forest, high (altitude) volcanic regions, and remote marine islands. Gastrointestinal problems may occur. Skin poisoning or disorders from overexposure to sun is not uncommon if students do not exercise appropriate pre-cautions. Individuals with certain medical conditions which can lead to electrolyte imbalance such as inflammatory bowel disease, diabetes mellitus and insipidus, 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.

The physical challenges of this program are considerable. Students may need to walk up to 10 miles a day with a full pack, ascending altitudes as high as 2500 feet in one day. Climbing, diving and carrying will be required. In some cases, it may be possible for a student to remain behind if the demand of a particular site are too challenging for his/her condition. In these cases, provisions will be made for the student to complete an alternate assignment at a more suitable site where more extensive care is available.

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 guidelines permitted by customs regulations.

If additional space is required, please attach report.

(Physician's/Health Provider's evaluation continued)

Diagnosis:

Medications and dosages:

Special diet or dietary restrictions:

Stability of condition over past two years:

PHYSICIAN'S STATEMENT (CONT'D)

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

Program: Australia and New Zealand

Recommendations for the care of this individual:

Is this individual capable of participating in the above named study abroad program? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, are there particular activities or environments from which the student should be restricted? (describe)

Signature of physician or health care provider: \_\_\_\_\_

Name of provider (printed): \_\_\_\_\_

Address/telephone: \_\_\_\_\_

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