Skidmore College Study Abroad
Health Assessment and Emergency Treatment Form

Name: _____ Gender: _____

Age: _____ Date of Birth: _____ Country of Residence: _____

Permanent Address: _____

Parent /Guardian Name(s): _____

Address (if different from above): _____

Home Phone: _____ Business Phone #1: _____

Business Phone #2: _____

Known allergies to medications/food/insects: _____

_____

_____

_____

List any medications student takes on a regular basis:_____

_____

_____

_____

Are there any other health considerations the program needs to be aware of should you require emergency medical care? (i.e., previous hospitalization, history of family illness, treatment of a psychological condition, etc.)

_____

_____

_____

_____ _____

Signature of Student Name of Student (please print)

Permission for Emergency Treatment

In the event of an emergency illness or injury affecting, (student's name), _____ born (date) _____, the undersigned hereby authorizes immediate hospitalization and treatment recommended and carried out under the supervision of a qualified health professional, including administering an anesthetic and performing necessary surgery and the release of whatever medical information may be required to perform the procedure or treatment.

_____ _____

Signature of Student Name of Student (please print)

_____ _____

Signature of Parent Name of Parent (please print)

_____

Date

THIS SIDE TO BE COMPLETED BY YOUR PHYSICIAN/HEALTH CARE PROVIDER

IMMUNIZATIONS The following required immunizations must be completed before the Health Assessment form will be accepted and before the program starts: (NOTE: Two measles shots are required one year beyond the date of birth.) There may be additional location specific immunizations required or recommended.

Required: (please provide immunization dates)

Tetanus-Diphtheria Booster (within last 10 years) (1) _____ Mumps Vaccine (1) _____

Measles (Rubeola) Vaccine (1) _____ (2) _____ Poliomyelitis Vaccine Booster (1) _____

German Measles (Rubella) Vaccine (1) _____

Recommended:

Bacterial Meningitis Vaccine: ___ Menomune (polysaccharide) _____ **OR** ___ Menactra (conjugate) _____

Hepatitis A: (1) _____ (2) _____

Hepatitis B: (1) _____ (2) _____ (3) _____ **OR** Twinrix (Hepatitis A & B): (1) _____ (2) _____ (3) _____

Varicella Vaccination (if no history of chicken pox): (1) _____ (2) _____ **OR** History or Chicken pox (see below)

PERSONAL HISTORY

Circle the disease or conditions the student has or has had and give details below:

Asthma	Emotional instability	Menstrual cramps
Chicken Pox	Epilepsy	Operations (specify)
Chronic intestinal problems	Heart problems	Orthopedic problems
Diabetes	Injuries (severe)	Rheumatic Fever
Drug and/or Food allergy (specific)	Kidney disease	Seasonal allergy
Eating disorders	Lung problems	Sleep disorder
Eczema	Malignancy	Tuberculosis or TB Contact

Details:_____

_____

_____

Current Medical Problems:_____

_____

PHYSICAL EXAMINATION

Weight_____ Height_____ Blood Pressure_____ No problems found _____ Blood Type_____

Problems as noted below: _____

_____

Is it necessary for the student to be on a specific diet? If yes, please give details_____

_____

What allergies, including medication allergies, does the student have?_____

Is the student taking any medication? If yes, what?_____

Is there any additional medical information which would be of help to our Director during a semester or year of study and travel abroad?_____

Treatment:

Full details of any medical treatment to be given during the Skidmore Program Abroad must be recorded. (This means any treatment prescribed for this patient by any physician or licensed provider.)

_____

_____

Examining Physician/Health Care Provider:

Print Name:_____ Telephone:_____

Address:_____

Signature:_____ Date:_____