

Skidmore College Study Abroad Health Assessment 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: _____

Health Insurance Information

Skidmore College requires all students studying abroad on Skidmore Programs to have international health insurance that covers them while abroad. Skidmore College students are covered for the term of their program through ACE American Insurance, policy# SDHN00575215. Non-Skidmore students, studying abroad on Skidmore programs, are covered for the term of their program through Cultural Insurance Services International (CISI). This policy will be purchased and paid for by Skidmore College. Information on both of these policies is available through the Office of International Programs. Note: these policies only cover you for the term of the program. Students traveling overseas prior to the start of their program, or staying after the program completion date, are not covered through the Skidmore provided policies. Students will need to purchase additional insurance to cover them for these periods, unless their personal health insurance policy offers international coverage. Some student international identification cards, available online, offer basic international medical insurance. These cards are fairly inexpensive and may be an option if your personal health insurance policy will not cover you abroad.

Permission for Emergency Treatment

On rare occasions a student participating in an overseas study program faces a health emergency requiring hospitalization and immediate treatment. To prevent dangerous delay in such an emergency, Skidmore College strongly recommends that the student and his/her parent or guardian sign the following statement and that the student carry it on his/her person at all times while she/he is abroad:

In the event of an emergency illness or injury affecting myself, (student's name) _____, born (date) _____, the undersigned hereby authorizes immediate hospitalization and treatment recommended and carried out under the supervision of a qualified physician, including administering an anesthetic and performing necessary surgery.

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)

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 | Maligancy | 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: _____