Appendix M - Medical History Form

Name _____Program (country) _____

Student ID _____

Answer every question with words – not check marks, blanks or other symbols. Use ink.

1. Blood type (if known) _____

2. What illnesses, conditions or injuries have you had medical treatment for in the past five years?
   _____
   _____

3. Are you currently under treatment for any physical or emotional condition? Please explain.
   _____
   _____

4. List any ongoing physical or emotional conditions which might require immediate treatment abroad due to changes in climate, diet or exercise. What treatment is recommended?

   _____

5. Are you currently taking any medication(s) on a regular basis? If so, please name.

   _____

   Please describe for what purpose the medication(s) is/are prescribed, e.g. Claritin for allergies

   _____

6. Which medications are you allergic to?

   Aspirin _____

   Sulfa Drugs _____

   Penicillin_____

   Other (Please Name) _____

7. Do you wear contact lenses?
   _____

8. What other substances are you allergic to? (i.e. bee stings, foods, plants, animals, etc.)

   _____
   _____

9. Do you have any condition or handicap which might prevent you from climbing steps? participating in excursions or other activities? If yes, please describe.
   _____
   _____

10. Are you on a restricted diet? If so, give details.

    _____
    _____

Your physician: _____

Name _____

Address _____

Telephone _____Fax _____

Please note that failure to disclose any and all medical conditions may result in removal from the program. A doctor's letter releasing you to participate may be required.

Signature (in ink):_____ Date: _____