HEALTH / MEDICAL REPORT

PERSONAL INFORMATION

Full Name (As on passport):			
Date of Birth:			
Passport Number:		Gender:	Male Female
Citizenship:			
Principle Address			
Cell Phone:		Email:	

EMERGENCY CONTACTS

You must provide two emergency contacts. Please check that these people will be available while you are in the semester in case we need to contact them. Your contacts should not be individuals who are traveling with you.

Emergency Contact #1			
Full Name:			
Relationship to you:			
Cell Phone:		Email:	

Emergency Contact #2			
Full Name:			
Relationship to you:			
Cell Phone:		Email:	

HEALTH DECLARATION

The Health Declaration is a vital part of this form. This section also requires your signature.

- Please answer the questions in the participant portion of this section accurately, including as much detail as possible so that we can determine your suitability to the coastal semester and can accommodate you to the best of our ability
- Accurate completion of this Health Declaration will be helpful if you have a medical emergency while on the semester. You must alert coastal staff of any changes to your medical status or medications that occur after submission of this Health Declaration.

Height (ft/in):		Weight (lbs):	

Have you ever had any of the following conditions? Please check all that apply and provide as much additional detail as possible for any condition you have. Your form will not be considered complete without this requested information.

Anemia		Epilepsy / Seizures		Migraines/Severe Headaches	
Cancer		Head injury		Musculoskeletal conditions (osteoporosis, fibromyalgia, etc.)	
Chronic lung conditions		Heart conditions (including disease, murmur, irregularity)		Nervous system conditions (multiple sclerosis, Parkinson's, etc.)	
Chronic back conditions		Heat and/or cold sensitivity		Orthopedic problems (sprains, strains or fractures)	
Cognitive disorders (Alzheimer, memory loss, dementia, etc.)		High blood pressure		Skin conditions	
Dizziness/balance conditions		Immune system conditions		Sleep apnea	
Eating disorder		Kidney or liver conditions		Stomach/intestinal conditions	
Endocrine/thyroid conditions		Malaria		Tuberculosis/exposure to TB	
Lyme disease		Fainting spells		Other (please specific below)	

Additional Information: Append additional paper if this space is not sufficient.

Asthma		Cause:		Do you selfmedicate	Yes No
Diabetes / Hypoglycemia		Cause:		Do you selfmedicate	Yes No
Active Hepatitis:		Type:			
Have you been hospitalized or had surgery in the past two years? If yes, please include provide as much detail as possible in the space below.					Yes No
Do you have any phobias which might inhibit your participation? If yes, please describe in the space provided below.					Yes No

Do you have any allergies? Include drugs, food, insect stings etc. If yes, list the type of reaction, the severity, and required treatment. Please indicate any medications you will be carrying to treat your allergy.	Yes No
Do you have any conditions that are not already indicated above?	Yes No
If you have any of the conditions listed above, please provide as much detail as possible here, including dates of treatment/surgery, and potential effects on your participation on this project.	

We may need to contact you to discuss your condition to assess how it may affect your ability to safely and effectively participate in the Coastal Semester.

MENTAL HEALTH – This information is private and will never be shared publicly.

Have you ever been diagnosed with or been treated for a psychiatric condition such as bipolar disorder or depression? If yes, please provide details:	Yes No
Have you ever been hospitalized or in residential treatment for psychiatric care? If yes, please provide the dates of hospitalization/treatment:	Yes No

Do you suffer from claustrophobia, anxiety, ADHD or other related conditions for which you take medication of any sort? If yes, please provide details below.	Yes No
May we contact your psychologist/psychiatrist? If yes, please provide name and number below:	Yes No

MEDICATIONS

Do you take or have you ever taken any prescription or non-prescription medications for any reason? If yes, please list the medication, reason for taking it, length of time you have been taking it, and the current dosage.	Yes No

Medication	Reason for taking	Date started	Dosage
Please add any additional information here:			

INSURANCE INFORMATION

Medical Insurance Company					
Policy #:	Group #:				
Are you the primary policy holder?	Y		N		
If NO please provide the following					
Name of Primary Policy Holder					
Date of Birth					
Social Security Number of Policy Holder (if not yourself)					

PARENT OR LEGAL GURADIAN SECTION

(*Must be filled out if student is under 18 years old.)*

THE LAW requires that parental permission be obtained for procedures on minors. The following consent form should be signed by a parent or guardian so that such procedures may be promptly carried out with no unnecessary delays. However, no major operation will be performed, except in extreme emergency, without parents being contacted and fully informed.

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter/ward. I also give permission for information to be released to my insurance company as deemed necessary.

Signed _____

Relationship _____ Date _____

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PHYSICIAN SECTION

Please provide this form to your doctor to fill out.

(*We cannot accept reports filled out by a parent physician.)*

_____ (student name) is planning to spend an academic semester traveling along the Mid-Atlantic Coast of the United States with Hood College's Coastal Studies Semester. The information you provide regarding the student's health will assist our office in anticipating and dealing with any health problems that may arise during her or his travel experience with us.

Please use this form to evaluate the physical and mental health of the student, adding any details not covered by the questionnaire. Your reply will be kept strictly confidential. Return the completed evaluation in the envelope provided by the student, or by email to Catherine Gaudlip gaudlip@hood.edu.

I am the student's:	Family physician		College physician		Other	
If "Other", please describe:						
Date of last Physical Exam:		How Long have you known the student?				
Student's general health is:	Excellent		Good		Poor	
Immunizations and dates received:	Tetanus: Y N Date:_____		MMR: Y N Date:_____		Polio: Y N Date:_____	

If the answer to any of the following questions is "Yes", please give details on a separate sheet. In each case, please indicate whether the condition is likely to affect the student's full participation in the program.

	Yes	No
1. Is the student significantly underweight or overweight?		
2. Is the student allergic to any form of medication? If yes, please specify:		
3. Has the student ever suffered from asthma or any other respiratory ailment?		
4. Is the student currently under treatment or observation for any physical or emotional condition?		
5. Is there any history of eating disorders?		
6. Does the student have any speech, hearing, or eyesight impairment that might affect participation in the program?		
7. Does the student have any physical disability whose effects might be amplified with diet changes, carrying luggage, or strenuous travel?		
8. Might the student require assistance from an aide or other second party at some time during the program due to an existing condition?		
9. Is there any congenital malformation now existing that may require additional treatment?		
10. Does the student have a history of emotional disturbance?		
11. Has the student shown any:		
a. difficulties in relations with authority figures or peers?		
b. behavioral disorders?		
c. symptoms such as mood swings, depression, severe sleep disorders, unusual degrees of anxiety, fear, or guilt?		
12. To your knowledge, are there any predisposing medical, surgical or emotional factors that may, under stress or duress during the program, present a need for immediate treatment while traveling?		
13. **Based on the physical and mental health of the student, should she or he, to the best of your knowledge, be able to complete a full semester program of study and residence while traveling?**		

Physician's name: _____

Please print

Physician's signature: _____

Mailing address: _____

Number/Street/Post office box

_____

City or town State/Province or Country Zip or Postal code

Telephone: (_____) _____ Fax: (_____) _____

E-mail address: _____