



TENNESSEE CONSORTIUM FOR INTERNATIONAL STUDIES MEDICAL HISTORY FORM

Name \_\_\_\_\_ Program \_\_\_\_\_ (please print)

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. \_\_\_\_\_
\_\_\_\_\_

11. 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: \_\_\_\_\_ Date: \_\_\_\_\_