



**APPENDIX R
Medical History Form**

Name _____ Program (country) _____

Student ID _____

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

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: _____