



Medical Report Form

Name (please print)

Program

Term(s)

Year

Insurance:

Prior to departure, you should contact your current insurance carrier concerning coverage for accidents, illnesses, and liability cases that occur outside the United States. Check your policy's limitations before making any assumptions about coverage. It is possible to purchase supplementary insurance for abroad should your personal/family insurance be insufficient.

It is mandatory for Clark students to be covered by medical insurance during their entire time abroad! You must have medical insurance covering you at all times and in all places you visit. For example, you cannot use the British National Health Insurance to waive this requirement.

Recommendations on vaccinations and country-specific health data are available from the Center for Disease Control (CDC). Their Web site is www.cdc.gov.

Most U.S. based insurance companies will not cover property lost or stolen overseas. It is important that you read all policy information carefully and note exactly what coverage is provided; be sure to take note of items that are excluded from coverage. Clark strongly recommends that coverage, beyond that which is provided as part of the program, is secured and understood by the participant before departure.

To the Applicant:

Please fill out the Medical History Self Evaluation that is attached and then give the form to your physician to complete. Participation in the program is, among other requirements, contingent upon Clark University's Office of Study Abroad Programs receiving a completed medical report from you and your physician. Your doctor should complete this report based on an examination within four months of the program departure date. Your physician should either mail the form directly back to **Clark University Study Abroad Office, 950 Main Street, Worcester, MA 01610, or return it to you, the student, in a sealed envelop, signed across the closing flap.** Please be sure the physician knows the deadline for returning this form to Clark University.

Also, make sure to explain in detail the program you are applying for. For example, going to Beijing in China is difficult with severe asthma considering the severe air pollution in the city. Namibia, with a 12-day rural stay without electricity and running water, is very different from living in the dorms at The University of Stirling.

It is important to know that students with recent/current emotional or psychological problems should consult a mental health professional in the United States to discuss the potential stress of studying abroad. Mental health treatment is not as widely accessible abroad as it is in the United States and might not be available at all.

Note: It is our policy not to accept reports filled out by a parent-physician.



Medical History Self Evaluation

Participant's Name: _____

Program of Study: _____

Term: _____

To be completed by the applicant: Every item must be completed. If more space is needed than is available, please attach the information on a separate page. This form should remain attached to the form your physician completes. If you are under the care of multiple physicians, each health care provider should complete the attached form.

A. Please check "yes" or "no" to the following:

- | | | | |
|-----------------------------------|--|--------------------------------|--|
| 1. Heart Disease | yes <input type="checkbox"/> no <input type="checkbox"/> | 12. Vision/Hearing Impairment | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 2. Chest pain/pressure | yes <input type="checkbox"/> no <input type="checkbox"/> | 13. Diabetes | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 3. Heart Palpitations | yes <input type="checkbox"/> no <input type="checkbox"/> | 14. Hepatitis or Jaundice | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 4. Unexpected sweating | yes <input type="checkbox"/> no <input type="checkbox"/> | 15. Arthritis | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 5. Shortness of Breath | yes <input type="checkbox"/> no <input type="checkbox"/> | 16. Altitude/Motion Sickness | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 6. Dizziness/Fainting | yes <input type="checkbox"/> no <input type="checkbox"/> | 17. Eating Disorders | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 7. Muscle Cramps | yes <input type="checkbox"/> no <input type="checkbox"/> | 18. Sleep Disorders | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 8. High Blood Pressure | yes <input type="checkbox"/> no <input type="checkbox"/> | 19. Epilepsy/Seizure Disorders | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 9. Asthma/Lung Disease | yes <input type="checkbox"/> no <input type="checkbox"/> | 20. Mental Illness | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 10. Intestinal Disturbances | yes <input type="checkbox"/> no <input type="checkbox"/> | 21. Headaches | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 11. Foot, Leg, or Back Irritation | yes <input type="checkbox"/> no <input type="checkbox"/> | 22. Skin Irritation | yes <input type="checkbox"/> no <input type="checkbox"/> |

B. If you checked "yes" to any of the above, please explain in detail below:

C. Please list any prescription medications you currently are taking and the condition(s) for which they were prescribed:

D. Do you currently have any medical problems, under the regular care of a physician or other health provider? Please explain.

E. Are you currently under the care of a psychiatrist, psychoanalyst, psychologist, or other mental health provider? If so, please attach a statement or letter from the medical specialist.

F. Does your health prevent you from participating in any physical activities? Please explain.

G. Have you been hospitalized in the past five years? Please explain.

H. Please list all allergies (medications, foods, insects, other agents, etc.) and describe their effects:

I. If you require special support due to a learning disability, please attach a letter from Disability Services specifying the special support you receive on campus.

J. Below, list any dietary restrictions you have. Please explain and mention vegetarianism, veganism, pescatarian, etc. Be sure to include an explanation of what you can and cannot eat according to your specific diet.

I hereby certify to The Study Abroad Office (OSAP) that I have fully informed Clark University of any previous and existing health, physical or psychological conditions which could hinder my participation in the program, and that I am solely responsible for my medical, psychological, and physical condition for the duration of my program. I am aware of any medical, psychological, and physical problems that would, in any way, impair my ability to participate in this program. Should any health problems arise during the course of my program, I am solely responsible for obtaining any and all medical care coverage for any such care, including, but not limited to, adequate insurance coverage for the cost and expenses of trip cancellation, evacuation, baggage loss or damage, trip interruption, travel accident/sickness, and medical care.

Signature of Participant

Date

Signature of Parent or Legal Guardian (if under 18)

Date



Medical History Physician Evaluation

Participant's Name: _____

Program of Study: _____

Term: _____

To the Patient: Should additional medical information be required by the examining physician, I, _____, consent to release and request any pertinent medical information from my primary physician.

Primary Physician: _____

Address: _____

Phone: _____

Signed: _____

To the Physician: You are being asked to provide information on the physical and mental health of this student planning to participate in a Study Abroad/Study Away Program. Program elements and duration vary, depending on where he or she will be going. The pressures of living and studying abroad are considerable. It is extremely important that all participants be able to adjust to dramatic changes in climate, diet, and living conditions. Living overseas can also create emotional and physical stress for those not able to meet the demands of living in a new and different environment. In some cases, mild disorders can become serious under the stress of life in foreign surroundings. Students generally live in university dormitories or in homes with local families; in some cases, participants live and study in situations that offer few amenities and little privacy. For example, Beijing, China might not be suitable for students with severe asthma due to the high level of pollution; the Namibia program includes a 12-day home stay in a rural area without electricity and running water. Immunizations are required for certain program locations. Please have the student explain to you the character of the program abroad s/he is applying to. **This form should be mailed directly to the Study Abroad Office at Clark University, 950 Main Street, Worcester, MA 01610 or placed in a sealed envelop, signed across the closing flap, and given to the student patient.**

It is essential that your reply be based on a current and thorough physical examination and knowledge of the applicant's medical history. Any additional comments relevant to the patient's physical or psychological condition should be provided on a separate sheet, signed and dated by you, the physician.

A. How long have you known the patient?

B. Are you:

1. Applicant's family physician
2. College Physician
3. Other

C. Please indicate the following of the applicant:

1. Height:
2. Weight:
3. Blood Pressure:
4. Pulse:
5. Skin:

D. Is your patient under the additional care of any other doctors? If yes, please provide specific information regarding their specialty.

E. Is the applicant seriously underweight or overweight?

F. Is the applicant currently taking any medications?

G. Is the applicant allergic to any form of medication?

H. Has the applicant received any of the following immunizations? Please provide the date of the last immunization.

1. Diphtheria, Pertussis, Tetanus (DPT)
2. Mumps, Measles, Rubella (MMR)
3. Polio
4. Hepatitis A
5. Hepatitis B
6. Typhoid
7. Other

I. Has the applicant ever suffered from asthma or any other respiratory ailment?

J. Is the applicant currently under treatment or observation for any physical or emotional condition?

K. Does the applicant have any speech, hearing, or eyesight impairment that might affect participation in the program?

L. Will a physical disability of the applicant cause hardship through change of diet, carrying luggage, or strenuous travel?

M. In your judgment, will the applicant require assistance from an aide or other second party because of an existing condition at any time on the program?

N. Is there any congenital malformation now existing that may require additional treatment?

If yes, what is this condition and what treatment is to be pursued? (Please note that many insurance plans do not include treatment for preexisting conditions.)

O. Does this person have a history of emotional disturbance? Has the applicant displayed any of the following? Please explain (circle those that apply)

1. difficulties in relations with parents, authority figures, peers
2. behavior disorders
3. symptoms such as mood swings, depression, severe sleep disorders, unusual degree of anxiety, fear or guilt

P. 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 therapy while abroad? Please explain.

To the best of your knowledge, from a medical point of view, can you recommend participation in the study abroad program the student is applying for?

Yes No

Any additional comments relevant to the patient's physical or psychological condition should be provided on a separate sheet signed and dated by you, the physician

Physician's Name

Physician's Signature

Date

Physician's Address (Street, State, Zip)

Please mail this form directly to the Clark University Study Abroad Office, 950 Main Street, Worcester, MA 01610, or return it to the student in a sealed envelop, signed across the closing flap.