

HEALTH FORM

Program_____

The purpose of this Health Information Form is to: 1) make the program's faculty director aware of any medical or psychological condition which may affect or be affected by your participation in the program and 2) provide information about your health history that will be helpful to medical officials in the event of a medical emergency. It is not intended to exclude your participation in the program. All information will be kept confidential and is accessible only by the Director of International and Off-Campus Programs, the Director of Health Services, the faculty and staff of the individual program in which you intend to participate, and medical personnel. Candid evaluation of your medical condition and discussion as to whether your medical needs can be met while away from home is the best way to safeguard your well-being.

Complete this Health Form which includes a Travel Medical Questionnaire.

Read all information thoroughly. Ultimately, you are responsible for your own health and safety while participating in your chosen program.

Name_____

Permanent Address_____

_____Tel._____

Date of Birth_____M_____F_____

Whom should we contact in the event of an emergency?

Name_____

Address_____

_____Tel._____

All students who participate in an international or off-campus program must retain valid health insurance during the length of their program. Drew University and the Office of International & Off-Campus Programs provide emergency medical, evacuation and repatriation insurance. However, it does not provide sufficient basic medical coverage. The Drew University Insurance policy provides internationally valid coverage. If you are not covered by Drew Insurance, you must check with your carrier to see if your insurance provides international coverage.

Please provide the information below regarding your internationally valid health insurance provider.

Name of Company_____

Subscriber's Name_____ Policy #_____

We recommend that you carry certification of health insurance coverage and claim forms.

TRAVEL MEDICAL QUESTIONNAIRE

NAME: _____ AGE: _____

DATE: _____

DESTINATION: _____ LENGTH OF STAY: _____

ALLERGIES: _____

MEDICATIONS: _____

1) Do you have any medical condition that warrants regular medication or physician follow up? _____
if yes, please explain. _____

2) Do you have a medical condition that is stable now, but may be aggravated by travel? (i.e. skin disorders or chronic diarrhea) _____

3) Have you ever had a convulsion, seizure, or epilepsy? _____

4) Do you get frequent episodes of diarrhea or constipation? _____

5) Have you ever had hepatitis or had yellow jaundice? _____

6) Do you have a history of psychiatric problems? _____

(This includes depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorder)

7) Are you pregnant? _____

8) Do you have frequent episodes of insomnia? _____

9) Have you ever been diagnosed with psoriasis? _____

10) Do you have any heart condition or take medication for heart problems or high blood pressure?

11) How many times have you traveled outside of the US? _____

Signature of Student

Date

Signature of Health Provider

Date

HEALTH INFORMATION

To the Student: In the event of illness or injury to _____ (participant's name) authorize the Director of the Drew University International and Off-Campus Programs in _____ (program location), to secure any treatment that may be considered necessary, including the administration of an anesthetic and surgery.

I authorize my physician or the Drew University Health Service Office to release my immunization record and information regarding my health status relevant to my participation in my chosen program to the Director of International and Off-Campus Programs, the Director of Health Service, the faculty and staff of the individual program in which I will participate, and medical personnel. I agree to record any vaccinations received after completion and submission of this form in an International Certificate of Vaccination card and to carry this information with me on my chosen program. Further, if I become aware, subsequent to submitting this form, of any medical or psychological conditions that may affect my participation in an international or off-campus program, I agree to disclose this information to the faculty leader directing the international or off-campus program in which I will participate.

Date _____ Student's Signature _____

Parent's Signature (if participant is under age 18) _____

To the Physician: This student will participate in a Drew University sponsored international or off-campus program. Your honest evaluation of his/her condition is appreciated.

Please list all vaccinations this student has received in the past 10 years, including dates:

Does this student have any significant, underlying medical or psychological conditions or life threatening allergies, or take prescription drugs on a daily basis of which an international or off-campus programs director or qualified physician should be aware in the event of a medical emergency? If so, please explain.

Participation in a study abroad program can be physically and mentally demanding. Any pre-existing medical or psychological condition or use of prescription medication may place the student at risk. I have discussed this matter with this student and believe that he/she is prepared to participate in the program to which he/she has been accepted.

Date _____ Physician's Signature _____

Return completed form to: The Office of International & Off-Campus Programs. Thank you.