CLAREMONT McKENNA COLLEGE

**Health Report**
Study Abroad/DC/SVP

Name _____ ID # _____

Program Sponsor:_____ Program Site: _____

***An off-campus study program may pose emotional and physical challenges for those living in a different environment for an extended period of time. At the discretion of the OCS office, a copy of this report may be sent to CMC administration, the host institution, and/or program sponsor.***

Failure to self-disclose an ongoing medical condition that needs treatment while away may result in a lack of proper medical attention and support while off-campus.

**Section I** To be completed by the student.

My off-campus program will be in _____ (city), _____ (country).

My program is (check all that apply): ❑ Classroom/campus based ❑ Experiential/Field Based ❑ Office Based

1. Birth Date _____/_____/_____ Sex _____

2. In your estimation, how would you describe your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

3. Do you have any food allergies or dietary restrictions? ❑ Yes ❑ No If yes, please explain.

_____

4. Do you have any known allergies to medication or vaccines? ❑ Yes ❑ No If yes, please explain.

_____

5. Are you allergic to any other elements, e.g., bee stings, pollen, etc.? ❑ Yes ❑ No If yes, please explain.

_____

6. Please check any of the following conditions you may have had or currently experience.

| | Date | | Date | | Date |
|---|---|---|---|---|---|
| ❑ Anemia | | ❑ Ears, frequent infection | | ❑ Kidney Disease | |
| ❑ Anxiety or Panic Attacks | | ❑ Eating Disorder | | ❑ Menstrual Difficulty | |
| ❑ Arthritis | | ❑ Epilepsy/Seizures | | ❑ Mental Health Counseling | |
| ❑ Asthma | | ❑ Fainting/Blackouts | | ❑ Migraine Headache | |
| ❑ Attention Deficit Disorder | | ❑ Hay Fever | | ❑ Mononucleosis | |
| ❑ Bipolar Disorder | | ❑ Hearing Difficulty | | ❑ Pneumonia | |
| ❑ Blood Clotting Disorder | | ❑ Heart murmur/Arrhythmia | | ❑ Positive Tuberculin Skin Test | |
| ❑ Cancer | | ❑ Hepatitis | | ❑ Sinus Disease | |
| ❑ Depression | | ❑ High Blood Pressure | | ❑ Other _____ | |
| ❑ Diabetes | | ❑ Immune System Problem | | ❑ I have none of the conditions listed. | |

7. Medications (please list by name): _____

8. Explain any recent or serious health episodes. (attach supplemental information or explanation if necessary.

_____

In many countries abroad, there is no comprehensive legislation that protects individuals covered by the Americans with Disabilities Act (ADA). These cultures do not recognize the special needs which might affect those persons with physical, psychological, or learning disabilities. If you have a special need or disability that might impact your experience abroad, you are well advised to discuss it with study abroad staff before departure. Any special accommodations must be supported with documentation prior to the start of the program.

**Do you have any medical, physical, psychological, learning disability, or personal needs that you would like to discuss with a study abroad advisor? ❑ Yes ❑ No**

**Due to medical/privacy laws, the Dean of Students Office cannot inform the OCS office nor your study abroad provider concerning any special accommodations for a learning difference. Do you have any accommodations you would like to discuss with the Off-Campus Study Office? ❑ Yes ❑ No**

**I hereby verify that all of the information contained in this form is accurate and complete and acknowledge that any failure to provide accurate and complete information may result in OCS revoking approval for study abroad. I agree to notify the OCS office of any material changes in my health that occur prior to the start of the program.**

Student Signature_____ Date: _____

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**Section 2** To be completed by a medical provider. OCS does not accept reports completed by a physician related to the student.

1. Is the information provided by the student in Section I of this report complete and correct to the best of your knowledge?
❑ **Yes** ❑ **No** If no, please explain.

_____

_____

2. Is the student currently on medication or receiving medical treatment? ❑ **Yes** ❑ **No** If yes, please explain including start date of medication.

_____

_____

3. Will the student continue medication while studying off-campus (abroad, in Washington DC or in Silicon Valley? ❑ **Yes** ❑ **No**

_____

_____

4. Does the student have any recent medical or surgical condition that could require attention while studying off-campus?
❑ **Yes** ❑ **No** Please note any other information, including details of current treatment, if any, which could be helpful to the physician who would be treating this student while abroad (use additional paper if necessary).

_____

_____

5. Does this student have any ongoing physical or emotional condition, disability, or impairment that may cause hardship during an extended stay off-campus in the destination described in Q1, student section? ❑ **Yes** ❑ **No** If yes, please elaborate.

_____

_____

6. Height _____ Weight _____ BMI_____ Does the student have an eating disorder? (please explain)

_____

_____

7. Based upon both pages of this form, do you have any concerns or comments about the student's ability to have a safe off-campus experience at the indicated program site, city, and/or country? Please explain.

_____

_____

_____

Signature _____Date_____

❑ Physician's name (print) _____

❑ Physician's Assistant/ Nurse Practitioner's name (print) _____

_____
Street Address

_____
City State Phone