

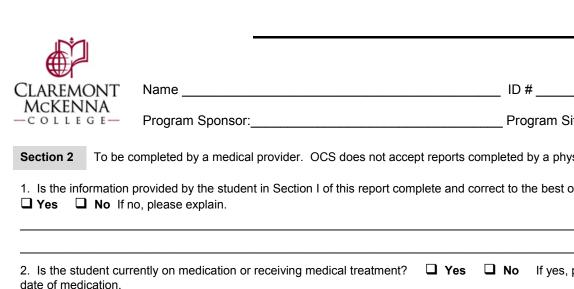


Name	ID #
Program Sponsor:	Program Site:

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.

medical attention and support w	<u>'nile off-campus.</u>							
Section I To be completed by the	e student.							
My off-campus program will be in	(city),	(country).						
My program is (check all that apply			Based					
liviy program is (check all that apply	). Glassiooni/campus based	■ Experiential/Fleid	Daseu					
1. Birth Date//	Sex							
		□ Eveellant □ Coo	d Desir Desir					
2. In your estimation, how would you describe your general health?								
3. Do you have any food allergies of	or dietary restrictions? 🗖 Yes 🗖 N	lo If yes, please expla	ain.					
4. Do you have any known allergie	es to medication or vaccines? 🗖 Ye	es 🛘 No If yes, pleas	se explain.					
5. Are you allergic to any other eler	ments, e.g., bee stings, pollen, etc.?	Yes 🗆 No If yes	s please explain					
	neme, e.g., see emige, penen, e.e	_ 100 _ 110	з, рючос одржии.					
			_					
6. Please check any of the followin	g conditions you may have had or o	currently experience.						
<u>Date</u>	=	<u>Date</u>	<u>Date</u>					
□ 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/Arrhythm	ia 🗆 🗆	Positive Tuberculin Skin Test					
☐ Cancer	☐ Hepatitis		Sinus Disease					
☐ Depression	☐ High Blood Pressure		Other					
□ Diabetes	☐ Immune System Probler	m	I have none of the conditions listed.					
7. Medications (please list by nam	e)·							
		1.6						
8. Explain any recent or serious he	ealth episodes. (attach supplementa	al information or explana	ation if necessary.					
In many countries abroad there is	no comprohensive legislation that n	rotocte individuale covo	ared by the Americans with					
In many countries abroad, there is	res do not recognize the special ne							
			act your experience abroad, you are we					
			s must be supported with documentation					
prior to the start of the program.	. , ,	•	• •					
Do you have any medical, physic	cal, psychological, learning disab	ility, or personal need	Is that you would like to					
discuss with a study abroad adv		<b>y</b> , o. <b>p</b> o.co						
Due to medical/privacy laws, the	Dean of Students Office cannot i	inform the OCS office	nor your study abroad provider					
	odations for a learning difference		commodations you would like to					
			te and acknowledge that any failure					
	e information may result in OCS i ges in my health that occur prior t		study abroad. I agree to notify the gram.					
Student Signature		Date	:					



☐ Physician's Assistant/ Nurse Practitioner's name (print)

State

Street Address

City

							Health Report
CLAREMON"	T Name				ID#	•	
MCKENNA -c o l l e g e-		or:					
Section 2 To	be completed by a med	ical provider. OCS	S does not acce	ot reports com	pleted by a physi	cian related	d to the student.
	tion provided by the student of the	dent in Section I of	f this report com	plete and corre	ect to the best of	your knowl	edge?
2. Is the student date of medicatio	currently on medication on.	or receiving medi	cal treatment?	☐ Yes ☐	<b>I No</b> If yes, plo	ease expla	in including start
3. Will the studer	nt continue medication v	while studying off-o	campus (abroad	, in Washingtor	n DC or in Silicor	า Valley?	☐ Yes ☐ No
☐ Yes ☐ No	lent have any recent me Please note any other e treating this student w	information, include	ding details of cu	irrent treatmen			
	lent have any ongoing pf-campus in the destinat	-		•		-	
6. Height	Weight	BMI	_ Does the	student have a	an eating disorde	er? (please	explain)
•	both pages of this form, erience at the indicated	-				ity to have a	a safe off-
Signature					Date		
☐ Physician's n	ame (print)						

Phone