Suffolk
COUNTY COMMUNITY COLLEGE

MEDICAL HISTORY & CLEARANCE FORM

STUDY ABROAD DESTINATION: _____

PARTICIPANT INFORMATION:

NAME: _____
First **Middle Initial** **Last**

STUDENT ID: _____

D.O.B: _____ **AGE:** _____ ❑ **FEMALE** ❑ **MALE**

FAMILY DOCTOR:

NAME: _____

ADDRESS: _____

PHONE: _____

MAJOR SURGERY: (please, provide details below if "yes"; attach additional pages as needed)

❑ Yes ❑ No

_____
_____

MEDICAL OR PSYCHIATRIC AID OR LONG-TERM COUNSELING OR BEEN HOSPITALIZED FOR EMOTIONAL PROBLEMS: (i.e. emotional/eating disorders, drug/alcohol problems, etc. – attach additional pages as needed)

❑ Yes ❑ No

_____
_____

ON-GOING MEDICAL CONDITIONS AND/OR MEDICATIONS: (if "YES", please, provide below medications and dosages; please, write clearly):

❑ Yes ❑ No

_____
_____
_____
_____
_____

ALLERGY HISTORY:

INHALANTS	FOOD INTOLERANCE	INSECTS	OTHER
❑ Yes	❑ Yes	❑ Yes	❑ Yes _____
❑ No	❑ No	❑ No	❑ No

DISABILITY OR CONDITION THAT MAY REQUIRE SPECIAL ACCOMODATIONS: (i.e. first-floor housing, alternative transportation, etc. – attach additional pages as needed)

❑ Yes ❑ No

_____

_____

LEARNING DISABILITIES THAT REQUIRE SPECIAL ACCOMODATIONS: (i.e. extended test time, separate testing room, etc. – attach additional pages as needed)

❑ Yes ❑ No

_____

_____

MEDICAL INFORMATION YOU WOULD LIKE TO DISCLOSE TO YOUR HOUSING FACILITY:

❑ Yes ❑ No

_____

CHILDHOOD ILLNESSES:

CHICKEN POX	MEASLES	MUMPS
❑ Yes	❑ Yes	❑ Yes
❑ No	❑ No	❑ No

PERSONAL AND FAMILY HISTORY: (Please check/circle appropriate box for history of the following)

❑ Heart attack, stroke	❑ Diabetes	❑ Emotional Disorder
❑ High Blood Pressure	❑ Cancer	❑ Hereditary Disorder
❑ High cholesterol	❑ Alcohol/Drug Abuse	

PHYSICIAN/ HEALTHCARE PROFESSIONAL RECOMMENDATION:

Based on the information provided to me by the participant and after a review of the participant's personal health history I find that:

❑ **There are medical or psychiatric contradictions to participation,** and in my judgement the ***participant is NOT cleared to study abroad.***

❑ **There are NO medical or psychiatric contradictions** to participation, and the ***participant is cleared to study abroad.***

❑ ***The participant is cleared to study abroad, BUT*** program leaders should note the following medical information and needs **(PLEASE, CONTINUE TO THE FOLLOWING PAGE):**

Serious active or chronic condition:_____
_____
_____
_____
_____
_____
_____
_____

Allergies: _____

Critical Medications Currently Prescribed, including dosage (PLEASE, WRITE CLEARLY):
_____
_____
_____

Please, place **Physician's Office stamp <u>HERE:</u>**

_____ ***Signature of Physician/Healthcare Professional***

_____ ***Printed name of Physician/Healthcare Professional***

_____ ***Date***

THE BELOW IS REQUIRED <u>ONLY IF THE PARTICIPANT IS CURRENTLY BEING SEEN BY A SPECIALIST</u> FOR SERIOUS ONGOING CONDITION:

_____ ***Signature of Specialist***

_____ ***Printed name of Specialist***

_____ ***Date***

_____ ***Phone Number/Address***

CLEARANCE FORM

IMMUNIZATIONS

I accept complete and absolute responsibility and liability for ensuring that I am properly immunized against conditions and diseases for the countries to which I am traveling. I represent and warrant that I am informed what the proper immunizations are for the countries. I further represent and warrant that I have confirmed with my physician and/or the U.S. Department of Health and Human Services - Centers for Disease Control and Prevention's website (www.cdc.gov/travel/) for updates and recommendations regarding immunizations for the countries to which I am traveling. I further represent and warrant that I have received all necessary and recommended immunizations.

EMOTIONAL AND PHYSICAL STRESS

Living and studying in a foreign environment, as required by the Study Abroad Program (the "Program") provided by Suffolk County Community College (the "College") may create unexpected physical and emotional stress, which may exacerbate otherwise mild disorders. I understand that it is important that I am able to adjust to dramatic changes in climate, diet, living conditions and studying conditions that may be disruptive to accustomed patterns of behavior. I understand that I should never assume that going abroad to study would provide an antidote to health problems experienced at home. I understand that if I fail to inform the College about a medical condition, medication or medical treatment that I have received/am receiving and there are related problems during the Program, it may result in my being dismissed from the program.

MEDICATIONS & TRAVELING ABROAD

If you regularly take prescription medications, bring a supply to last throughout your time abroad. Bring a letter (in your carry-on luggage) from your health care professional listing your medications, their dosage, their generic name, and a description of the condition being treated, and give your Program leader a copy of the letter upon arrival. This letter could be helpful in an emergency. Make sure all drugs you take with you are in the original pharmacy containers and are clearly labeled. You should carry copies of the prescriptions to avoid problems with Customs. Be sure to carry all prescriptions, medicines, and related paperwork in your carry-on luggage. In the case of narcotic medicines, you may not be able to carry additional supplies because of possible Customs difficulties. Instead, bring a prescription with the drug's generic name and a letter from your health care professional describing your condition. Most countries have very strict regulations on having medications shipped abroad, and in many countries it is illegal to ship it altogether. Check with the postal service and customs office well in advance. It is imperative that you discuss with your health care professional in the U.S. ahead of time how you will get medications that you need in your host country if you are not able to bring a full supply with you.

PARTICIPANT AUTHORIZATION & RELEASE

I authorize the College to seek and to obtain medical and surgical services, immunizations, and therapeutic procedures as deemed necessary by duly licensed healthcare professional. I am aware that due to the nature of traveling abroad, it may not be possible to obtain the same quality of health care that I would receive if were treated in the United States. I freely, knowingly and willingly choose to participate in the program and assume the associated risks and will take due care during such participation.

AUTHORIZATION FOR USE OF DISCLOSURE OF MEDICAL INFORMATION

This authorization is requested by the Participant to comply with the terms of the Confidentiality of Medical information Act of 1981, Civil Code Section 56, et seq. **I hereby authorize the release of information contained herein as the College deems necessary. I understand that this information will be used for the purpose of protecting participant's health during the term of the program identified on the form, or in the case of medical necessity while abroad.**

By signing below, I certify that the information contained herewith about my medical history is true and correct. Further, I agree to be bound by all the terms and conditions presented herewith.

X _____ _____

*Signature of Student (Parent /Legal Guardian-check below)** *Date*

X _____

Printed Name (Parent/Legal Guardian)

* I (A) am the parent/legal guardian of the above Participant, (B) have read the foregoing Release Form, (C) am and will be legally responsible to the obligations and acts of the Student as described in this Release Form, and (D) agree, for myself and for the Participant to be bound by all of its terms.