Study Abroad Medical Self-Assessment

Name _____ Doane ID: _____
As on passport: Last First Middle

DOB:_____ Passport # _____ SSN:_____

Campus Address:_____

Campus Phone:_____ Cell Phone_____

Permanent Address:_____

Home Phone:_____

Please provide a candid evaluation of your health- keeping in mind study abroad programs can physically and emotionally demanding. Information on this form is confidential to the Office of International Programs, Study Abroad Resident Director and Medical Staff abroad. Providing this information is voluntary, and will not be used to determine your enrollment in the program. Honest assessment of your health and medical history may be of assistance to you if an illness or emergency occurs while abroad.

If needed, please attach additional information on a separate sheet of paper.

Please rate your overall health (Please check one): Excellent Good Fair Poor

Height:_____ Weight:_____ M: __ F:__ Age:_____

Do you currently have, have you been treated, or are you currently being treated for:

Dietary restrictions, special diet, known food allergies?	YES NO
A physical health condition? (asthma, diabetes, epilepsy, heart condition, etc)	YES NO
A mental health condition (psychological or emotional)?	YES NO
Known allergies to medications, plants, animals, insect stings, etc.?	YES NO
Physical impairment, limitations or disabilities?	YES NO
Any pre-existing medical conditions?	YES NO

If you answered YES to any of the questions above, please explain:

In the past 2 years have you:

Had a major surgical operation or been advised to have one?	YES NO
Had a major illness or injury (rheumatic fever, etc.)?	YES NO
Been treated by a psychiatrist, psychologist or counselor?	YES NO
Received accommodations for a physical or learning impairment?	YES NO
Taken medication on a regular basis	YES NO

If you answered YES to any of the questions above, please explain:

Are you currently undergoing treatment, taking prescription medication, taking over the counter medication, herbal supplements or remedies ? YES NO

If YES, please explain:

If you will be taking any medication(s), supplements or remedies while abroad, please list them here:

Will you be treated for a pre-existing illness or chronic condition while abroad? YES NO

Will you be treated by a psychiatrist, psychologist or counselor while abroad? YES NO

Is there any additional information that would be helpful in case of emergency, illness or incapacitation?
Please explain:

Have you fully and truthfully completed the medical self assessment form? YES NO

Have you included additional details on a separate piece of paper? YES NO

I certify the information provided by me on this form is correct to the best of my ability. I give my permission to Doane University and its agents to contact the persons I have identified as my emergency contacts in the event the resident Director, Program Coordinator or agents of Doane College feel such action is justified.

Signature Date