Medical History Form for Off-Campus Study

Global Education Office (GEO)

Last Name_____ First Name_____ Birth Date _____

Instructions: Please complete this health history form to the best of your ability. It is used only to help arrange special accommodations when necessary or to assist you in emergencies. (This information is kept confidential and shared only when necessary as outlined in the release statement at the end of this form.)

My general health is: Excellent_____ Good_____ Fair_____ Poor_____

Allergies: Penicillin ___ Aspirin ____ Bee stings ____
Peanuts ___ Eggs ____ Environmental ____
Other (give details) _____

Diet: Regular _____ Vegetarian _____
Restricted (give details) _____

Medications (List names of all medications you are currently taking):
Inhalers_____
Birth Control_____
Psychological medications_____
Insulin injections/pump_____
Seizure medications_____

Other medications prescribed for medical or mental health conditions (give details):
_____
_____

Medical History: Hospitalization (give dates and type)_____
Surgery (give dates and type) _____

Health History:

Cancer/tumors	_____	Bladder/kidney problem	_____
Back/joint problem	_____	Ulcer/stomach problem	_____
Anemia/bleeding disorder	_____	Alcohol or other substance abuse	_____
Hepatitis/jaundice	_____	High Blood Pressure	_____
Headaches	_____	Heart Problems	_____
Thyroid problems	_____	Eating disorder	_____

Other _____

Please check below any medical or psychological conditions that have required psychological care within the past 5 yrs

Depression	_____	Anxiety Disorder	_____
Eating Disorder	_____	Bipolar Disorder	_____
OCD	_____	Anger Management	_____
PTSD	_____	Suicide Attempt	_____
Suicidal Ideation	_____	Self Harm	_____
Panic Disorder	_____	Conduct Disorder	_____

Other (Please List) _____

Release of Information: I understand that the information included in this health history may be shared with staff and/or faculty from KSC, The Center for Health and Wellness, Counseling Services, host school support services and/or medical providers for the purpose of protecting my health during the period of my participation in the study away program.

Signature: _____ Date:_____