

IES Medical Report – Customized Program

Part 1: Student Self Evaluation

Name _____ Home Phone _____
Home School _____ Program Location _____ Program Dates _____
Emergency Contact:
Mother/Guardian Name _____ Home Phone _____
Work Phone _____ Email _____
Father/Guardian Name _____ Home Phone _____
Work Phone _____ Email _____

TO BE COMPLETED BY THE STUDENT: Please complete and sign the front side of this form. You are responsible for coordinating with a physician, certified nurse practitioner or physician's assistant to COMPLETE THE SECOND PART OF THIS FORM AFTER HAVING A CURRENT EXAM and for returning the ORIGINAL form to your school representative by the specified due date. No other medical forms will be accepted in substitution.

Gender _____ M _____ F Date of Birth _____
Do you hold religious beliefs that might impact the provision of emergency medical treatment while you are abroad?
____ YES ____ NO If yes, give details. _____
Are you required to wear a health emergency bracelet? ____ YES ____ NO If yes, for what condition? _____

Have you had or do you currently have any of the following conditions? Please mark all that apply, specifying the date, whether past or current. If yes, please detail information. Attach additional sheets if necessary.

Medical Condition	Past Date	Current	If yes, please detail information.
1. Alcohol/Drug addiction	_____	_____	_____
2. Allergies	_____	_____	_____
3. Asthma	_____	_____	_____
4. Cancer	_____	_____	_____
5. Chronic Condition	_____	_____	_____
6. Diabetes	_____	_____	_____
7. Eating Disorder	_____	_____	_____
8. Epilepsy/Seizure Disorder	_____	_____	_____
9. Frequent Trouble Sleeping	_____	_____	_____
10. Heart Disease	_____	_____	_____
11. Hypoglycemia	_____	_____	_____
12. Painful shoulder, knee or back	_____	_____	_____
13. Thyroid Condition	_____	_____	_____
14. Other: _____	_____	_____	_____

Have you had any injuries, which have required hospital/ER attention? (i.e.: major accident, etc.) ____ YES ____ NO
If yes, when and for what? _____
Have you ever been hospitalized? ____ YES ____ NO If yes, when and for what? _____
Have you had any surgical procedures? ____ YES ____ NO If yes, when and for what? _____
What is your condition as a result of the surgery? _____
Are you currently taking any medications? ____ YES ____ NO If yes, which medications and for what? _____

Have you ever been treated for any psychological/emotional problems? ____ YES ____ NO If yes, list dates: _____
If yes, please describe the nature of the problem: _____
Did your treatment require medication? ____ YES ____ NO If yes, please list medications: _____
Current Status: _____

PLEASE NOTE: The following questions address disability-related needs of students. Provision of the following information is voluntary.
Do you have a documented disability as defined by the Americans with Disabilities Act? ____ YES ____ NO
If yes, please state the nature of the disability _____
In which areas does your disability currently impair your ability to perform daily academic activities? _____
Are you requesting any academic activity accommodations from IES for the above listed disability? ____ YES ____ NO
If yes, separately please provide documentation from a qualified professional that speaks to your current needs for accommodation. For Full consideration, this information must be submitted to your school coordinator by 5 weeks prior to the program start date.

*Receipt of the medical report after the deadline may result in delays with your housing placement

In signing this document, I verify that all of the medical and psychological information I have provided is accurate and complete, and I will notify IES hereafter of any relevant changes in my health that occur prior to the start of the program.

Student Signature _____ Date _____

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Part II: Physical Exam

TO BE COMPLETED BY EXAMINING PHYSICIAN (MD OR CERTIFIED NURSE PRACTITIONER/PHYSICIAN'S ASSISTANT ONLY):

ONLY after a CURRENT medical examination. No other medical forms will be accepted in substitution.

Home College: _____ **Center:** _____ **Dates:** _____

Patient's Name _____ **Height** _____ **Weight:** _____ **BP** _____

Date of Examination _____ **How long have you known the patient** _____

Please comment on the student's medical history by answering the following questions with Yes, No, or N/A.

Has the patient:

had any past surgeries? ___ YES ___ NO ___ N/A

ever been hospitalized? ___ YES ___ NO ___ N/A

had Asthma? ___ YES ___ NO ___ N/A

If yes, please provide details including dates

Please mark all conditions that CURRENTLY apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies of any kind | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Neurological condition |
| <input type="checkbox"/> Anaphylactic Shock | <input type="checkbox"/> Frequent indigestion or ulcer | <input type="checkbox"/> Reaction to antibiotics |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart or circulatory complications | <input type="checkbox"/> Recent gain of weight |
| <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Head injury | <input type="checkbox"/> Recent loss of weight |
| <input type="checkbox"/> Chronic respiratory problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Chronic digestive/g.i. problems | <input type="checkbox"/> Jaundice/hepatitis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Liver or gall bladder problems | <input type="checkbox"/> Trouble with eyes, ears, nose, throat |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dizziness/fainting spells | <input type="checkbox"/> Narcotic/alcohol dependency | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Psychological/psychiatric conditions | <input type="checkbox"/> Other: _____ |

Please explain any items identified and attach an additional sheet or Physician's report if necessary.

Is the student now taking any medication that he/she will be bringing with him/her on the IES study abroad program?

___ YES ___ NO If yes, please list all medication(s), dosage(s) and use(s):

Please comment in detail on any medical condition (in particular those listed above) that currently affects this student.

Is there any psychological condition that currently affects this student? ___ YES ___ NO

If yes, please comment:

To the best of my knowledge, the above named student has no physical or mental conditions that should prevent him/her from participating successfully in the IES study abroad program he/she plans to attend.

Physician's Signature _____

Date _____

Physician's Name (Please Print) _____

Physician's Address _____

Physician's Telephone _____

Please submit completed forms to your school representative by specified due date.

