SMITH COLLEGE

Smith College Programs in Florence, Geneva, Hamburg, Paris

Medical Review Forms

Smith College is committed to working with students to promote and support their health and safety while abroad. Prior to departure, students must submit this Medical Review Form. Since studying abroad often involves higher stress levels that may exacerbate existing physical or emotional conditions, we strongly encourage students to fully disclose their medical history. In doing so, the information provided will help the Smith College deans for international study and program directors ensure that students' needs are met. It is also critical that this information is available in case of an emergency and we ask that you sign a release permitting us to communicate the information to medical providers and emergency contacts. At the completion of the program, all student medical information will be destroyed.

Accommodations
University and living facilities in other countries may not meet American standards of accessibility for persons with physical or learning disabilities. If students require special accommodations because of a disability, please notify the Smith College Office for International Study (OIS) in writing. A letter from the Office for Disability Services documenting and confirming the request for accommodations will also need to be provided. Requests for accommodation should be submitted to the OIS by June 1 (or October 1 for spring programs). Smith's OIS will do all that it reasonably can to accommodate a student's needs.

Instructions
This Medical Review should be submitted to the Smith College Office for International Study, Wright Hall, Northampton, MA 01063.

Part I –**Medical Report** to be completed by student. Keep a copy of this form for your records and to submit to the doctor you ask to complete Part II. Part I should be submitted with your enrollment materials within three weeks of the offer of admission.

Part II -- **Medical Report** to be completed and signed by a physician or medical professional, nurse practitioner or physician's assistant. The information must be based upon a physical examination conducted within the past 12 months. Reports completed by a relative are not acceptable. If Part II cannot be completed before the enrollment deadline, include a note with an appointment date for the completion of Part II, preferably no later than June 1 for programs with a fall start or October 1 for programs with a spring start. Students need to be sure to sign the waiver at the top of the form.

Change of Status: You are responsible for notifying Smith College Office for International Study of any changes in your medical history prior to your departure and while on the program.

Updated January 2013

Smith College Office for International Study
Wright Hall, Northampton, MA 01063
Phone: 413-585-4905 Fax: 413-585-4982

Smith College Programs Abroad in Florence, Geneva, Hamburg, Paris

Part I: Medical Record – To be completed by student

This information will be kept on file during your enrollment on the program for use in an emergency; full disclosure is encouraged.

Name _____ Sex _____ Birthdate _____
Family, first, middle month/day/year

Program: _____ Term: _____

Home Mailing Address _____

_____
city state postal code country

Current Telephone _____ Home School _____

PERSONAL HISTORY – Please check if you have had:

- ☐ Tuberculosis
- ☐ Scarlet Fever
- ☐ Measles
- ☐ Rubella (German Measles)
- ☐ Chicken Pox
- ☐ Rheumatic fever
- ☐ Hepatitis
- ☐ Malaria
- ☐ Polio
- ☐ Other_____

SURGERY

- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Hernia repair
- ☐ Other _____

HABITS (how much/how often)

- ☐ Alcohol _____
- ☐ Tobacco _____
- ☐ Other _____

ALLERGY –if checked, give details on a separate sheet)

- ☐ Eczema
- ☐ Asthma
- ☐ Hay fever
- ☐ Foods _____
- ☐ Other _____

FAMILY HISTORY

	Age(s)	State of Health	Have any immediate family members had:	
Father	_____	_____	Tuberculosis _____	Asthma _____
Mother	_____	_____	Diabetes _____	Cancer _____
Brothers	_____	_____	Heart Disease _____	Other _____
Sisters	_____	_____	Epilepsy/convulsions _____	

REVIEW OF PAST ILLNESSES AND SYMPTONS

Please complete the following, *using additional paper to give detail as necessary*.
DO NOT LEAVE ANY QUESTION BLANK.

1. Has your physical activity been restricted during the past five years? Give reasons and duration.
   _____
2. Have you been hospitalized? If yes, give diagnosis and date. _____
   _____
3. Have you ever had a serious acute illness? If yes, give details. _____
   _____
4. Do you have any chronic/recurrent illness? If yes, give details. _____
   _____
5. Have you had any allergic reactions to prescription or over-the-counter medicines? If yes, give details.
   _____
6. Have you had any allergic reactions to immunizations? Explain. _____

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Part I: Medical Record – To be completed by student

7. Do you have a history of asthma or any other respiratory ailment? If yes, give details.

   _____

8. Do you take any prescription medications, including oral contraceptives, antidepressants, and psychiatric medications? List and give details.

   _____

9. Are you currently receiving antigen/immunotherapy injections or prescription medication for an allergy? List.

   _____

10. Do you have any health requirements or dietary restrictions based upon religion? Explain.

    _____

11. Do you have any habits that might adversely affect your health? Explain.

    _____

12. In the last five years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional or taken medications for conditions such as an eating disorder, depression, bi-polar disorder, etc? If yes, please explain on a separate sheet of paper.

    _____

Please check if you have had:

☐ Unexplained fever	☐ Immune system problems	☐ Stomach ulcer	☐ Epilepsy (seizures)
☐ Recent weight gain or loss	☐ Heart murmur	☐ Gall bladder trouble	☐ Recurrent dizziness
☐ Eye trouble	☐ Heart palpitations	☐ Hernia	☐ Depression
☐ Hearing loss	☐ Chest pain, pressure	☐ Kidney stone	☐ Severe headaches
☐ Sinus problems	☐ Chronic Cough	☐ Blood in urine	☐ Irregular periods
☐ Chronic rash	☐ Shortness of breath, wheezing	☐ Painful/swollen joint	☐ Severe cramps
☐ Anemia	☐ Abdominal pain	☐ Back problems	☐ Cancer or leukemia
☐ Chronic diarrhea	☐ Impaired use of any limbs		

Comment below on any conditions above that you have checked.

_____

_____

Emergency Contact Info

Person to contact in an emergency: _____ Telephone: _____

E-mail: _____ Relationship to student: _____

Authorization to Release Medical Records and Permission for Emergency Medical Treatment

As a participant in a Smith College Program Abroad, I hereby authorize the physicians and medical providers completing Parts II of this medical form, to release any and all medical records and information pertaining to me to Smith College Office for International Study. I also authorize the release by the Smith College Office for International Study of my medical records and information to my parent or other designated contact person in the event of an emergency.

On rare occasions, an emergency requiring treatment in a hospital and/or surgery may develop. In most cases, administration of an anesthetic, treatment of an injury, or operation upon an individual cannot be done without consent of the patient. In order to prevent a dangerous delay in an emergency situation where Smith College is either unable to contact my parent or guardian, or if I am unconscious or otherwise unable to give you my consent, I hereby authorize Smith College's representative to secure whatever medical treatment is deemed necessary, including administration of an anesthetic and surgery.

I hereby verify that all of the information contained in this form is accurate and complete, and acknowledge that any failure to provide accurate and complete information, including notification to Smith College of changes in my health affecting the accuracy or completeness of the information contained in this form, may result in my dismissal from the program. I agree to notify the Smith College Office for International Study of any material changes in my health that occur prior to the start of the program or while on the program.

Signature of Student _____ Date _____

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Part II: Medical Assessment– To be completed by medical professional

For the student:

Name of Student: _____ Program location and duration _____

As a participant in a Smith College Program Abroad, I hereby authorize the physicians and medical providers completing Part II this medical form to release any and all medical records and information pertaining to me to the Smith College Office for International Study.

Signature of Student _____ Date _____

To the examining medical professional:

Study abroad can be physically and mentally challenging. Mild or pre-existing health conditions can become serious for some students as they transition into an unfamiliar culture and environment. Some medications may also be difficult to obtain in other countries should they be lost or needed in an emergency. In order to ensure this student's well being, please review this student's health history. We request full disclosure of any health history that could potentially be problematic for this student, and that you provide additional information that could be useful in the event of treatment by a doctor or medical facility abroad. This information is strictly for the use of the Smith College Office for International Study.

1. Are there any abnormalities in the following systems?
   If none, check here**. ____** **If yes**, please give details on next page.

Yes	No		Yes	No	
___	___	Head, eyes, ears, nose or throat	___	___	Hernia
___	___	Teeth, gums	___	___	Metabolic/Endocrine
___	___	Skin	___	___	Genitourinary
___	___	Immune system, including lymph nodes	___	___	Pelvic
___	___	Cardiovascular	___	___	Musculoskeletal
___	___	Respiratory	___	___	Neurologic
___	___	Gastrointestinal	___	___	Mental Status

2. Blood Pressure _____ Temperature: _____ Pulse: _____ Respiration: _____ Height: ____ Weight: _____

3. Uncorrected Vision: Right 20/____ Left 20/ _____ Corrected Vision: Right 20/____ Left 20/ _____

4. Does this student have any physical, mental or emotional conditions that might affect her participation in this program? If so, please indicate the nature of the condition and treatment required while she is abroad:

5. Is this student currently under medical treatment or taking medication? Please list medications and treatment plan.

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Part II: Medical Assessment– To be completed by medical professional

6. Does this student have any allergies (including allergies to medication and/or food)? If yes, is there a history of asthma, anaphylaxis, and other dangerous allergic conditions?

7. Please give details any points of concern in this student's personal medical history, or your examination of the student if conducted.

(Add additional pages if necessary.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical Professional's Clearance

Having reviewed this student's medical history, I _____ ,
name of physician or medical professional

consider _____ able to participate in a Smith study abroad program in
name of student

_____ during the _____,
location of program term and year

with the following recommendations:

- ☐ none
- ☐ student needs access to discuss accommodation and/or access to medical and or mental health services *(i.e. counseling, exercise, etc…)* with a dean in the Smith Office for International Study
- ☐ student needs to receive an additional assessment by a specialist in the field of _____
- ☐ other: _____

Signature of physician or medical professional _____ Date: _____

Mailing address _____

_____

Telephone: _____ Fax: _____

Please return this form directly to the student.

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