

Medical Report Form
Nazareth College Valencia Program (PLEASE PRINT)

Applicant: _____ Date of Birth: _____

Dates of Participation in the Valencia Program: _____

TO THE STUDENT: *The purpose of this form is to help Nazareth College provide appropriate assistance to you should the need arise during your study abroad experience. Some medical or emotional problems can become serious under the stresses of life studying abroad. It is important that the program be made aware of any medical or psychological problems, past or current, which might affect you in a foreign study context. Please be honest. The information provided will remain confidential and will be shared with the program staff, faculty or appropriate professionals only as it relates to your health and safety. Nazareth College may not be able to accommodate all individual needs or circumstances.*

INSTRUCTIONS FOR THE STUDENT:

1. Complete and sign the Medical History section.
2. Have a medical physician complete the Physician's Report section, sign it, and return it to you.
3. Turn this form in to the Valencia Program Director as part of your application packet.
4. IF you will be studying abroad for MORE THAN ONE SEMESTER you will need to obtain a separate medical statement from your doctor on official medical letterhead to include with your student visa application. Please refer to student visa information.

MEDICAL HISTORY (to be completed by the student)

Circle YES or NO to answer the following questions. Please explain as indicated. Use a separate sheet of paper if necessary.

1. Do you have any medical conditions? YES NO (If yes, please explain)

2. Are you generally in good physical condition? YES NO (If no, please explain)

3. Are you currently under medical treatment? YES NO (If yes, please explain)

4. Do you have any allergies? YES NO (If yes, please explain)

5. Are you taking any medications? YES NO (If yes, please explain)

6. Do you suffer from any food allergies or have any dietary restrictions? YES NO
(If yes, please explain)

7. Do you have a disability that will require accommodations while abroad? YES NO
(If yes, please explain)

8. Do you have any additional health conditions other than those previously listed (such as surgeries, hospitalizations, injuries, chronic conditions, physical illness, psychological illness, emotional illness, mental illness, etc.) that may need special consideration before or during your experience or may affect your ability to participate in the program? YES NO
(If yes, please explain)

I certify that all of the responses on this Medical History form are true and accurate, and I will notify Nazareth College hereafter of any relevant changes in my health that occur prior to the start of the program.

Signature of Participant: _____

Date: _____

TO THE EXAMINING PHYSICIAN*: The above student is applying to participate in the Nazareth College Valencia Program. S/he will live in study in Valencia, Spain for a summer, semester or year. This report should be based upon an examination made within six months of the expected overseas participation. Health clearance is required for the student to participate in the program.

Living and studying in a foreign environment frequently creates unexpected physical and emotional stress, which can exacerbate otherwise mild disorders. It is important that all participants are able to adjust to potentially dramatic changes that may be seriously disruptive to accustomed patterns of behavior.

Please indicate your relationship with the student:

_____ Family Physician

_____ College Physician

_____ Other, please describe: _____

Steps in the Process:

1. The student must present to you a fully completed Medical Report Form. Please review the form carefully with the student for accuracy.
2. You must discuss/review the student's health history thoroughly referring to the Medical Report Form and the student's medical records on file, paying particular attention to medications and immunizations that the student may need, any allergies the student may have and all currently active health problems.
3. Pay special attention to any emotional or psychological conditions and any medications the student is taking. Nazareth College is especially concerned for the well-being of students who have eating disorders and/or students with psychological conditions that require medication and/or continued therapy while abroad. As you may know, these conditions may escalate to life threatening levels in a foreign environment. *Students may be cleared with these conditions provided they are in compliance with, and stable on their medication.*
4. Please impress on the student the need to take a sufficient amount of medication to last for the duration of experience or to determine that the medication is locally available and legal.
5. Clearly indicate on the attached form that you have discussed health and medication management and services that would be needed abroad in detail with the student. You may choose to have the student initial his/her consent that student understood the information provided on the attached form.
6. Assess the need for any continued counseling or laboratory testing while abroad so Nazareth College can determine the availability of adequate facilities at the program site.
7. List any physical, emotional, or learning disabilities the student may have, and be sure to specify the facilities or services required abroad on this form.

Students may be cleared for participation as long as, in the opinion of the examining practitioner and/or specialist, any medical condition they may have is under control and they have been stable on their medication for a reasonable period.

If a specialist or specialists is/are currently seeing the student for an ongoing medical or psychiatric condition, each specialist must also approve and sign this clearance form, and provide contact information. Please note that the student must be cleared to participate in the program by a physician/health practitioner AND each specialist, if the student is being seen by one or more specialists.

**Physician/Health provider/specialist must be licensed in the U.S. and cannot be an immediate family member.*

After evaluating the student health, please complete the attached form.

Health Clearance for Students Planning to Study Abroad

1. Review student's Medical Report Form, and medical records on file, with the student and discuss/review the student's health history thoroughly. After review, the Physician/Health Practitioner must carefully complete this form.
2. For students seeing a specialist for an ongoing condition, the approval and signature of the specialist (s) must be obtained before final clearance is signed by the Physician or Health Practitioner.
3. **IMPORTANT NOTE:** Legible names of the physician and the specialist, if student is seeing one, are required. **FORMS WITHOUT SIGNATURES AND THE REQUIRED INFORMATION WILL BE CONSIDERED INCOMPLETE** and will delay the student's compliance with program requirements. Please print clearly with a ball point pen. All lines and applicable boxes must be completed. **PLEASE RETURN THIS FORM TO THE STUDENT.**

First and Last Name of Student

I have read the attached information about the rigors of study abroad and have reviewed the student's Medical Report Form and medical records on file, with the student. Based upon the information provided to me by the student on the Medical Report Form, and pursuant to a review of the student's personal health history, to the best of my knowledge, the student is:

Licensed Specialist/Psychotherapist* (Section and signature required if checked)

1. **Conditionally cleared to study abroad:** Student should arrange the following before program participation
 - ___ 1.a Services that would facilitate the student's education (e.g. note taking, wheel chair access). Student should contact the on-campus Disability Services Office for a letter documenting disability and who will pay for services.

 - ___ 1.b Current need for services that would facilitate a healthy and safe stay abroad (e.g. regularly available psychiatric therapy, English-speaking therapist with expertise on eating disorders, etc.). Indicate that student is stable.

 - ___ 1.c Take a sufficient amount of medication to last for the duration of the overseas program or ensure that the medication is locally available and legal. If student is on medication, please list. Also, indicate if significant allergy to any medication.

2. **Student is NOT cleared to study abroad:** There are **medical contraindications** to participation.
3. **Student is NOT cleared to study abroad:** There are **psychiatric contraindications** to participation.
4. Student is **Unconditionally cleared to study abroad:** There are NO medical or psychiatric contraindications to participation.

Licensed Specialist/Psychotherapist: PLEASE CLEARLY PRINT name and title:

Phone number: _____
Signature: _____ Date: _____

Licensed Physician/Health Practitioner*

1. **Conditionally cleared to study abroad:** Student should arrange the following before program participation
 - ___ 1.a Services that would facilitate the student's education (e.g. note taking, wheel chair access). Student should contact the on-campus Disability Services Office for a letter documenting disability and who will pay for services.

 - ___ 1.b Current need for services that would facilitate a healthy and safe stay abroad (e.g. regularly available psychiatric therapy, English-speaking therapist with expertise on eating disorders, etc.). Indicate that student is stable.

 - ___ 1.c Take a sufficient amount of medication to last for the duration of the overseas program or ensure that the medication is locally available and legal. If student is on medication, please list. Also, indicate if significant allergy to any medication.

2. **Student is NOT cleared to study abroad:** There are **medical contraindications** to participation.
3. **Student is NOT cleared to study abroad:** There are **psychiatric contraindications** to participation.
4. Student is **Unconditionally cleared to study abroad:** There are NO medical or psychiatric contraindications to participation.

Licensed Physician/Health Practitioner (M.D., N.P., P.A., or R.N): PLEASE CLEARLY PRINT name and title:

Phone number: _____
Signature: _____ Date: _____

**Physician/Health provider/specialist must be licensed in the U.S. and cannot be an immediate family member.*

NON-DISCRIMINATION POLICY

It is the policy of Nazareth College of Rochester not to discriminate on the basis of race, color, religion, sex, sexual orientation, national or ethnic origin, age, marital or veteran status, or disability in the admission of student to the college; in any of the rights, privileges, programs, and activities accorded or made available to students at the college; in the administration of its educational policies, admission policies, scholarship and loan programs, and athletic and other programs administered by the college, or in the employment practices of the college.

Nazareth College reserves the right to cancel the program at any time for programmatic reasons.