LAFAYETTE COLLEGE
MEDICAL INFORMATION (FORM B)
For participation in Off-campus Study Programs

Please note: Disclosure of the following information is <u>voluntary</u>. However, it is in the best interest of each program participant to disclose any physical, psychological or other medical condition that may affect their health, wellness or safety during the trip abroad. This information allows us to identify and discuss your needs, assist you in making a contingency plan ahead of time, as well as to help provide optimal care to participants if the need arises.
Please be reminded that confidential physical health and mental health counseling is available at the Bailey Health Center (ext. 5001) and at Counseling Center (ext. 5005).

Name: _____ Sex:_____
(Last) (First) (Middle) (M or F)

Lafayette ID: _____ Date of Birth:_____
(L Number) (mm/dd/yyyy)

Home Address:_____
Number & Street City State ZIP

IN AN EMERGENCY, NOTIFY:
<u>Emergency Contact #1:</u>
Name: _____Relationship:_____
(Last) (First)
Home Address:_____
Number & Street City State ZIP
Cell Phone: _____Email Address: _____

<u>Emergency Contact #2:</u>
Name: _____Relationship:_____
(Last) (First)
Home Address:_____
Number & Street City State ZIP
Cell Phone: _____Email Address: _____

□ **I Decline to Disclose the Following Information.**

PERSONAL PHYSICIAN:
Name: _____ Phone:_____
(Last) (First)
Address:_____
Number & Street City State ZIP

Please answer ALL of the following questions. Do not leave any blank spaces: if the answer is none, write "none."

Clinical History

Are you currently under medical treatment? __ yes __ no
Do you have a chronic medical condition (asthma, diabetes, IBS, Crohn's, etc.)?
__ yes __ no If 'yes' please identify the condition(s) below:
_____
_____
_____

Have you had (or do you currently have) any psychological, psychiatric, or personal issues (including eating disorders, substance abuse, family concerns) during the past five (5) years for which you have sought professional services? __ yes __ no
If yes, please describe the circumstances:
_____
_____
_____

Are you currently taking any medications? __ yes __ no If yes, please list NAME OF PRESCRIPTION, condition being treated, dosage, prescribing clinician, and (if not listed above) contact information for that clinician.
NOTE: Please list all medications you take regularly, including those treating physical conditions (including any allergies) and psychological conditions (including depression, anxiety, or other psychological/emotional issue).

Name of medication	Condition	Dosage	Prescribing Clinician

Have you contacted your clinician and health insurance provider to obtain a sufficient dosage of this medication for the duration of your study abroad program? ___Yes ___ No
If "no" please list date when this contact will be made: _____

Please list any ALLERGIES to medication, food or other substances/conditions:
_____
_____

Please list any DIETARY RESTRICTIONS:
_____
_____

Have you had any diseases, surgical operations or significant injuries within the last five (5) years that could have an effect on your participation in this program? __ yes __ no
If yes, please explain:
_____
_____

Do you plan to have any surgical operations between now and your date of departure, which could affect your participation in this program? __ yes __ no
If yes, please explain:
_____
_____

Is there anything else about your health or medical history that may be a factor should there be an emergency? __ yes __ no If yes, please explain:
_____
_____

Disabilities

Do you have any conditions (including physical impairments or learning disabilities) that might restrict your mobility or require special facilities or accommodation while abroad? __ yes __ no

If 'yes,' are you registered with the ATTIC? __ yes __ no

Have you discussed these issues with the ATTIC staff, the Director of International and Off-campus Education (IOCE) and/or the faculty director(s) leading the program coordinator?
With ATTIC staff: __ yes __ no
With IOCE Director: __ yes __ no
With faculty director(s): __ yes __ no

If 'no', would you be willing to be contacted by either the ATTIC staff, the IOCE Director or the faculty director(s) to make arrangements to accommodate your needs while abroad? __ yes __ no

Authorization Statement

I hereby authorize Lafayette College to release information from my medical history, including but not limited to medical records, upon the request of the Office of International and Off-campus Education, and/or the faculty directors leading the program.
I understand that the Lafayette staff/faculty will not request any information from my medical records **unless a situation arises while I am a participant** in the off-campus program that makes it necessary to have the information pertinent to my safety or health.
I further understand that any information obtained from my medical records by the will be destroyed upon the completion of the off-campus study program.

I understand that, if I have a medical, psychiatric or psychological condition that requires or has required treatment, I must discuss my situation with my clinician.

I certify that the information on this Health Information Form is true and correct, and I will notify the Office of International and Off-campus Education at Lafayette hereafter of any significant or relevant changes in my health that occur prior to or during the off-campus study program.

Student's Signature: _____

Printed Name: _____ Date: _____

11/4/2016