Student Health Information

To be completed at least 4 weeks prior to your departure!

ERAU Summer Study Abroad Programs

Name:_____

Last First Middle

Program:_____

Location Abroad Dates of Program

To the student: The information provided will be housed in the ERAU Wellness Center and pertinent information will be shared with the faculty leading your trip in order to better support you while overseas. Be aware that you will be responsible for your own health while abroad, although ERAU and any host organization we are working with will provide what assistance they can. Please be honest with yourself and prepare accordingly. The questions that follow will help guide you in preparing for your stay abroad. Indicating that you have health concerns will assist us in preparing you for your time overseas and will help us support you. When complete, please return to the Wellness Center on your campus. **Please visit the Wellness Center as soon as possible!**

1. Do you have or have you ever had any physical, psychological, or emotional conditions (including eating disorders), that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? If yes, explain below and plan to see your health care provider to discuss your care.	Yes	No
2. Have you arranged to receive all necessary immunizations and medications recommended for visiting the program site by reviewing information that • may have been provided to you by ERAU; • may have been provided by the program site/provider; • is available on the US Centers for Disease Control and Prevention website; and • may be available from the government of the countries you will enter?	Yes	No
3. Do you have any allergies, reactions to medications, or dietary restrictions? If yes, consider what you may need to manage your condition or restrictions. If needed see your health care provider for assistance in planning for your care. Please list any allergies or dietary restrictions below.	Yes	No
4. Are you currently taking or have you recently discontinued taking any medications you may need while abroad? If yes list any medication name and purpose. Please consider how you will have access to the medication you need and consult with your physician to develop a plan for managing your condition while abroad. Depending on the medication, ERAU may request additional information.	Yes	No
5. For programs where malaria may be prevalent. Will you be taking anti-malarial prophylactics? If yes please indicate which prophylactic you will be taking.	Yes	No
6. ***(Disclosure of disabilities is optional)*** Do you have a disability for which you are receiving accommodations? If yes provide a description of desired accommodations. Please be aware that the Americans with Disabilities Act (ADA) does not apply outside the boarders of the United States. The program provider and or the host campus will assist you to the extent possible to obtain the accommodations you want; however, it may not be possible to obtain the accommodations necessary to enable you to participate in all aspects of the overseas program.	Yes	No

Continued on next page

7. Person to notify in case of emergency, illness or accident:

Name: _____ relationship to student_____

Street apt# _____ daytime telephone_____

City, state, zip_____ evening telephone number_____

Email address_____ cell #_____

Second person in the event the above cannot be reached:

Name: _____ relationship to student_____

Street apt# _____ daytime telephone_____

City, state, zip_____ evening telephone number_____

Email address_____ cell #_____

Student Declaration

I grant Embry-Riddle Aeronautical University, its employees agents and overseas partners permission to share information concerning my health condition with program representatives, my family, insurance company representatives and with my physician, psychologist or counselor who treated my during the last five years or is now treating me. In situations where I am unable to give oral or written consent, I grant permission for hospitalization and treatment recommended and carried out under the supervision of a qualified physician, including administering anesthetics and performing necessary procedures at my own expense. I appoint the representative of ERAU in the host country of the program to act on my behalf in authorizing necessary medical, dental, or surgical care, hospitalization or medical evacuation for me should this be required. If I choose to withhold information about my mental or physical condition, I understand that the program director may decide to send me back to the States earlier than the program ending date, at my own cost, if my condition becomes a problem for myself, my host family, or the program.

I certify that all responses made on this form are true and accurate and that I will notify the Study Abroad Office hereafter of any changes in my health that occur prior to the start of the program.

_____

Student's Signature Date

_____

Parent/Guardian's Signature (required if student is under 18 years of age) Date

If you answered yes to 1, or 4 or, no to 2 please make an appointment with your health care provider to review your medical history and travel plans and have her/him sign below.

To the Treating Clinician: Please review the student's medical history; discuss with her/him the upcoming overseas study plans and sign below. **Please complete the attached Physical Form.**

I have reviewed this student's medical history and examination with her/him, consulted with her/him about vaccinations and medications that may be required, and developed a treatment plan for the student to manage her/his condition during the overseas program, if needed.

_____

Signature of Provider Printed Name of Provider

_____

Address and Phone Number of Provider

Program Location and Dates:_____

Name:_____ Sex: F M Age:_____

Date of Birth:_____ Phone: _____ Box:_____

In Case of emergency: Name: _____

Relationship:_____ Phone: (H)_____ (W)_____ (C)_____

1. Have you had a medical illness or injury since your last check up or sports physical? □ Yes □ No
2. Do you have an ongoing or chronic illness? □ Yes □ No
3. Have you been hospitalized overnight? □ Yes □ No
4. Have you ever had surgery? □ Yes □ No
5. Are you currently taking any prescription or non-prescription (over –the-counter) medications or pills or using inhaler? □ Yes □ No
6. Have you ever taken any supplements or vitamins to help gain or lose weight? □ Yes □ No
7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? □ Yes □ No
8. Have you ever had a rash or hives develop during or after exercise? □ Yes □ No
9. Have you ever passed out during or after exercise? □ Yes □ No
10. Have you ever been dizzy during or after exercise? □ Yes □ No
11. Have you ever had chest pain during or after exercise? □ Yes □ No
12. Do you get tired more quickly than your friends do during exercise? □ Yes □ No
13. Have you ever had racing of your heart or skipped heartbeats? □ Yes □ No
14. Have you ever had high blood pressure or high cholesterol? □ Yes □ No
15. Have you ever been told you have a heart murmur? □Yes □ No
16. Has any family member or relative died of heart problems or a sudden death before age 50? □ Yes □ No
17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? □ Yes □ No
18. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? □ Yes □ No
19. Have you ever had a head injury or concussion? □ Yes □ No
20. Have you ever been knocked out, become unconscious, or lost your memory? □ Yes □ No
21. Have you ever had a seizure? □ Yes □ No
22. Do you have frequent or severe headaches? □ Yes □ No
23. Have you ever had numbness or tingling in your arms, hands, legs, or feet? □ Yes □ No
24. Have you ever had a stinging, burning, or a pinched nerve? □ Yes □ No
25. Have you ever become ill from exercising in the heat? □ Yes □ No
26. Do you cough, wheeze, or have trouble breathing during or after activity? □ Yes □ No
27. Do you have asthma? □ Yes □ No
28. Do you have seasonal allergies that require medical treatment? □ Yes □ No
29. Do you use any special protective or corrective equipment, (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? □ Yes □ No
30. Have you had any problems with your eyes or vision? □ Yes □ No
31. Do you wear glasses, contacts, or protective eyewear? □ Yes □ No
32. Have you ever had a sprain, strain, or swelling after injury? □ Yes □ No
33. Have you had broken or fractured any bones or dislocated any joints? □ Yes □ No
34. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? □ Yes □ No

If yes, check appropriate box and explain below.

□ Head	□ Elbow	□ Hip
□ Neck	□ Forearm	□ Thigh
□ Back	□ Wrist	□ Knee
□ Chest	□ Hand	□ Shin/calf
□ Shoulder	□ Finger	□ Ankle
□ Upper arm		□ Foot

35. Do you want to weigh more or less than you do now. □ Yes □ No
36. Do you feel stressed out? □ Yes □ No
37. Record the dates of your most recent Tetanus shot? _____

FEMALES ONLY:

38. When age was your first menstrual period? _____
39. When was your last menstrual period? _____
40. Are your periods regular? □ Yes □ No
41. Have you missed any period in the last year? □ Yes □ No
42. Do you have severely painful periods? □ Yes □ No

Explain "Yes" answers:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Student Name:_____

****

Clinic Use Only:

Height: _____ Weight: _____ BP: _____ Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected □ Yes □ No Pupils: Equal _____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen/Hernia		
Genitalia (Males only)		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand		
Hip/thigh		
Knee		
Leg/ankle		
Foot		

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of student:_____ **Date:** _____

Signature of Parent/guardian _____ **Date:** _____

(Students under age 18 years of age)

□ **Cleared for travel**

□ **Cleared after completing evaluation/rehabilitation for:**_____

_____

□ **Not cleared for (Reason):** _____

_____

Recommendations: _____

Signature of Physician _____ **Date:** _____