



ACADEMIC STUDIES ABROAD

Medical History Form

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The information on this form will not be used to deny participation in the program. It will be used in case of emergency only. Please answer all questions honestly. **PLEASE FILL OUT THIS FORM COMPLETELY – ALL 3 PAGES.**

(Please type or print in ink.)

STUDENT INFORMATION

First & Last Name _____

Term & Year of Program _____

Social Security Number _____

Date of Birth _____ Age _____

Country of Birth _____ Sex _____

Present mailing address _____

City _____ State _____ Zip _____

Phone Number (with Area Code) _____

Permanent mailing address _____

City _____ State _____ Zip _____

Phone Number (with Area Code) _____

Email address _____

PERSONAL AND FAMILY HISTORY

Are all of your parents and siblings alive? Yes No

If no, please give cause of death, relationship to you and any other significant health problems they may have had. Attach additional pages if necessary.

Have you had major surgery? Yes No

Year _____ Describe _____

Have you or a relative (e.g. parents, siblings or grand-parents) experienced any of the following?

	<u>Self</u>	<u>Relative</u>
Heart attack, stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emotional Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hereditary Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever received medical or psychiatric aid or long-term counseling or been hospitalized for emotional problems (i.e. emotional/eating disorders, drug/alcohol problems)? If yes, please describe on reverse.

Yes No

Do you have any on-going medical condition and/or medications? Yes No

Diagnosis _____

Treatment _____

Do you have a disability? Yes No

Describe _____

Allergy history (*if yes, please specify your allergy*)

Inhalants Yes No

Food Intolerance Yes No

Insects Yes No

Medications Yes No

Other Yes No

Childhood illness

Chicken Pox Yes No

Measles Yes No

Mumps Yes No

Are you covered by your own or parents' Health Ins. Policy? Own Parents None

FAMILY DOCTOR

Name _____

Phone Number (with Area Code) _____

ACADEMIC STUDIES ABROAD

MEDICAL HISTORY FORM

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PLEASE MAKE SURE THAT YOU HAVE THE PROPER IMMUNIZATIONS FOR THE COUNTRIES IN WHICH YOU PLAN TO TRAVEL. PLEASE CHECK WITH YOUR PHYSICIAN AND/OR THE U.S. DEPARTMENT OF HEALTH ([WWW.CDC.GOV/TRAVEL/INDEX](http://www.cdc.gov/travel/index)) FOR UPDATES AND RECOMMENDATIONS.

YOU MUST ALSO SUBMIT A PROOF OF PHYSICAL EXAMINATION TO ASA AT LEAST 2 WEEKS PRIOR TO DEPARTURE. IN ORDER TO FULFILL THIS REQUIREMENT, YOU WILL NEED TO SCHEDULE A PHYSICAL EXAMINATION AND HAVE YOUR DOCTOR COMPLETE OUR PROOF OF PHYSICAL EXAMINATION FORM.

STUDENT AUTHORIZATION AND RELEASE

I AUTHORIZE ACADEMIC STUDIES ABROAD TO SEEK AND TO OBTAIN MEDICAL AND SURGICAL SERVICES, IMMUNIZATIONS, AND THERAPEUTIC PROCEDURES AS DEEMED NECESSARY BY DULY LICENSED PERSONNEL. DUE TO THE NATURE OF TRAVELING ABROAD, IT MAY NOT ALWAYS BE POSSIBLE TO OBTAIN THE QUALITY OF HEALTH CARE AVAILABLE IN THE UNITED STATES.

I EXERCISE MY OWN FREE CHOICE TO PARTICIPATE VOLUNTARILY IN PROGRAM ACTIVITIES AND ASSUME ASSOCIATED RISK AND PROMISE TO TAKE DUE CARE DURING SUCH PARTICIPATION. I HEREBY RELEASE AND DISCHARGE, IDENTIFY AND HOLD HARMLESS ACADEMIC STUDIES ABROAD, INC. AND ANY OTHER PERSONS OR ENTITIES ACTING ON ITS BEHALF, AND THE SUCCESSORS AND ASSIGNS FOR ANY AND ALL OF THE AFOREMENTIONED PERSONS AND ENTITIES, AGAINST ALL CLAIMS, DEMANDS AND CAUSES ACTING WHATSOEVER, EITHER IN LAW OR EQUITY, RELATING TO INJURY, DISABILITY, ARISING FROM MY PARTICIPATION IN THE ACADEMIC STUDIES ABROAD, INC. PROGRAM. I UNDERSTAND THAT I AM SOLELY RESPONSIBLE FOR ANY COSTS ARISING OUT OF ANY BODILY INJURY OR PROPERTY DAMAGE SUSTAINED THROUGH MY PARTICIPATION IN NORMAL OR UNUSUAL ACTS ASSOCIATED WITH THE ACADEMIC STUDIES ABROAD, INC STUDY ABROAD PROGRAM. I BELIEVE I AM IN GOOD HEALTH, AND AFFIRM THAT MY PARTICIPATION IN THE ACADEMIC STUDIES ABROAD, INC. PROGRAM WILL IN NO WAY AGGRAVATE ANY CONDITION(S) PRESENT. IF IN DOUBT, I WILL SEEK FURTHER MEDICAL ADVICE.

FOR ALL STUDENTS

BY SIGNING BELOW, I VERIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS CORRECT. IF ANY OF THE ABOVE INFORMATION IS FOUND TO BE UNTRUE, I UNDERSTAND THAT I WILL BE IMMEDIATELY DISMISSED FROM THE PROGRAM FORFEITING ANY REFUND OF FEES PAID.

STUDENT SIGNATURE _____ DATE _____



ACADEMIC STUDIES ABROAD

Emergency Contact Sheet (PAGE 2 OF 3)

Please complete as much of the following information as possible.

Mother's first and last name: _____

Mother's home phone number: _____

Mother's work phone number: _____

Mother's cell phone number: _____

Father's first and last name: _____

Father's home phone number: _____

Father's work phone number: _____

Father's cell phone number: _____

Step-mother's first and last name: _____

Step-mother's home phone number: _____

Step-mother's work phone number: _____

Step-mother's cell phone number: _____

Step-father's first and last name: _____

Step- father's home phone number: _____

Step- father's work phone number: _____

Step- father's cell phone number: _____

Alternate emergency contact first and last name _____

Relationship (i.e. grandmother, aunt, friend, etc.) _____

Alternate's home phone number: _____

Alternate's work phone number: _____

Alternate's cell phone number: _____

OF THE PEOPLE LISTED ABOVE, WHOM SHOULD ASA CONTACT FIRST IN AN EMERGENCY AND ON WHICH PHONE NUMBER?

YOUR SIGNATURE _____ **DATE** _____