STAR SERVICE
& STUDY ABROAD

10. Confidential Medical Information Form

First Name _____ Last Name _____

Email Address _____ Phone Number_____

Permanent Street Address _____

City _____ State_____ Zip Code _____

Information regarding an applicant's health is important in anticipating and dealing with health problems which may arise during the student's stay abroad. A health record is confidential and accessible only to health personnel and Star Service & Study Abroad staff. An applicant will not be rejected due to either their physical or emotional condition unless it is of such nature as to prevent successful participation in the program, medical care for a patient's medical problem is not available in the country in which the applicant will study, and/or the living and environmental conditions to which the applicant could be exposed would present a risk to the health of the individual.

I. PERSONAL INFORMATION

- To be completed by the participant -

I understand that any travel, highway travel, and travel within the United States and foreign countries involves some risk and that participation in SSSA is entirely voluntary. I am aware that though Star Service & Study Abroad takes necessary precautions to prevent harm to participants, SSSA cannot assure that participants in the program will not be injured or exposed to dangers and risks that may result in serious injury, loss, harm, disease or illness.

Medical History

1. Do you have any significant chronic medical conditions requiring ongoing medical supervision and treatment, or have you had in the past any significant condition which is currently in remission? (Ex. allergies of any kind, asthma, diabetes, heart problems, chronic or recurrent gastrointestinal disorder, seizure disorder, treatment for cancer, bleeding disorder, etc.)

No _____ Yes_____ (if yes, please describe)

_____

_____

_____

_____

2. Are you currently receiving, or have you received in the past two years, counseling for any emotional problem, drug addiction, alcoholism, psychiatric condition or eating disorder?

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

2. Are you currently taking any medication(s)?

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

3. Do you have any dietary restrictions or food allergies?

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

I have advised SSSA of any health and physical or psychological problems that I have. In the event of injury or illness to me, I accept full financial responsibility and agree to release SSSA from any and all responsibility from any such medical claim, lawsuits, damages, expenses or liabilities. I will notify SSSA hereafter of any relevant changes in my health that occur prior to the start of the program.

By signing this document, I have read, understand, and agree to the terms above.

Signature _____ Date_____

II. MEDICAL CLEARANCE

Instructions

Participants are to fill out Section A of this form with their personal information. After completing Section A, participants must bring this form to their primary care physician who is to review, complete and sign Section B. The health provider must be licensed in the U.S. and cannot be an immediate family member of the participant. The Medical Clearance Form will be returned to the health practitioner if it does not have the participant's name or is missing information. A primary care physician may approve and sign this Medical Clearance Form if s/he is willing to provide the health clearance and is willing to be the contact person for this participant when s/he is in the education abroad program. If a specialist or specialists is/are currently providing treatment to the participant and the primary physician does not want to take responsibility for the specialists' medical judgment, each specialist also must approve and sign this Medical Clearance Form, and provide legible contact information.

Section A

First Name _____ Last Name _____ DOB ____/____/____

Email Address _____ Phone Number_____

Permanent Street Address _____

City _____ State_____ Zip Code _____

Section B

1. Does the student have any physical or emotional problems which might cause hardship through change of location and/or travel?

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

2. Does the student have any dietary, allergic or other medical conditions requiring special medical attention that might not be available in a foreign setting? (orthodontics, contact lenses….)

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

3. To your knowledge, does the student have any predisposing medical, surgical or emotional factors which may, under stress or duress during a program, present a need for immediate therapy while away?

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

4. Please list any serious illnesses the student has had in the last three years.

_____
_____
_____
_____

5. Does the student possess the physical and mental well-being required to: live and study in the applicable foreign setting where resources may be different or fewer than those to which they are accustomed; exercise good judgment; and safely fulfill all essential components of the education abroad program, including appropriate standards of conduct?

No _____ Yes_____ (If no, please explain)

_____
_____
_____
_____

6. Does the student have a condition that would prevent them from being able to live in a setting quite different from that to which they may be accustomed and that may aggravate any existing health conditions (e.g., dormitories or residences that may not be air conditioned or afford privacy, homestays with local families, etc.).

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

7. Does the student have a condition that would prevent them from participating in program related excursions and activities, which may include moderate activities such as hiking, walking, and/or other recreational sports and in some cases more strenuous activities, where heat or cold may be a factor, based in the particular education abroad program? If yes, please explain.

No _____ Yes_____ (if yes, please describe)

_____
_____
_____
_____

8. Is this individual capable of participating in the program to which he/she is applying?

Yes _____ No _____

I have reviewed thoroughly the above information, the participant's health and the medical records on file for the individual in question. To the best of my knowledge, there are no medical, psychological, or emotional problems to preclude participation in a student exchange/study abroad program. If such problems do exist I have disclosed them in this form.

Based on the information contained in the participant's medical records and provided to me by the participant, both in person and on file, to the best of my knowledge, the individual in question is capable of participating in the program to which she/he is applying:

Yes _____ No _____

Physician's report for (student's name): _____

Printed physician name _____

Signature of physician _____

Telephone: _____

Address: _____

Physician's office stamp

One copy of this form is to be kept on file by the health care professional who performed this clearance. The participant shall also retain a copy for her/his personal records. The participant must provide the original copy of this form to Star Service & Study Abroad along with her/his enrollment forms prior to the date of her/his anticipated departure.