

HEALTH ASSESSMENT FORM

CARLETON COLLEGE OFF-CAMPUS STUDIES One N. College St., Northfield, MN 55057 Phone: (507) 222-4332

PART I: TO BE COMPLETED BY STUDENT- within the six months prior to departure

A). STUDENT/FAMILY INFORMATION – *please write neatly*

Seminar/Program Name _____ Term _____
Student Name _____ Class yr. _____ Gender _____ DOB _____
Home Address _____
Cell Phone _____ E-mail address _____
Mother/Guardian Name _____
Emergency Phone Number _____
Father/Guardian Name _____
Emergency Phone Number _____

B). CERTIFICATION

I certify that the information below is complete and correct to the best of my knowledge.

I understand that if my health changes for any reason (accident, surgery, deterioration of a chronic condition, etc.) between the time I submit this form and the beginning of the program, I must submit to the Off-Campus Studies Office a written statement from a licensed medical provider whom I have seen within two weeks of my departure, describing my current state of health and the advisability of my participation in the program.

STUDENT MEDICAL RELEASE: I agree to the release of this medical information to the faculty director of the program in which I am participating and to the Carleton College OCS Staff. I further authorize the exchange of this information with authorized medical personnel in The Wellness Center for the purpose of providing my health care during my off-campus study experience. This release remains effective through the last day of the program unless rescinded by me in writing at any time.

Student Signature _____ Date _____

C). CURRENT & PAST MEDICAL HISTORY

Note: *Even mild physical or psychological problems could become serious during the physical and emotional stress of off-campus study. It is important that we be made aware of any medical or emotional problems past or current.*

Please check if you currently have or have had any of the following:

<input type="checkbox"/> chicken pox	<input type="checkbox"/> diabetes	<input type="checkbox"/> mononucleosis	<input type="checkbox"/> ear, nose, throat trouble
<input type="checkbox"/> hepatitis A	<input type="checkbox"/> arthritis	<input type="checkbox"/> substance abuse	<input type="checkbox"/> high/low blood pressure
<input type="checkbox"/> hepatitis B	<input type="checkbox"/> insomnia	<input type="checkbox"/> motion sickness	<input type="checkbox"/> depression/anxiety/other
<input type="checkbox"/> measles	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> stomach problems	<input type="checkbox"/> recent 10 lb. weight loss/gain
<input type="checkbox"/> mumps	<input type="checkbox"/> eye problems	<input type="checkbox"/> convulsions/epilepsy	<input type="checkbox"/> heart murmur/rheumatic fever
<input type="checkbox"/> anemia	<input type="checkbox"/> back problems	<input type="checkbox"/> kidney disease/injury	<input type="checkbox"/> head injury/loss of consciousness
<input type="checkbox"/> asthma	<input type="checkbox"/> eating disorder	<input type="checkbox"/> diarrhea/constipation	<input type="checkbox"/> hemophilia/clotting disorder/blood problem
<input type="checkbox"/> malaria	<input type="checkbox"/> German measles		

Do you smoke? Yes ___ No ___

List medications you are currently taking: _____

List allergies (medications, bees, food, pollens): _____

Has there been a change in your health since your college entrance? If so, please specify: _____

Do you have any health condition that is stable now, but could recur during off-campus study? Yes ___ No ___

If so, please specify: _____

D). INSURANCE

Does your health insurance cover you at the program site? (*Call your insurance company for answer*) Yes ___ No ___
(If no, please contact Off-Campus Studies before submitting this form)

Name of Health Insurance Company _____

Address _____

Tel. No. _____ Policy No. _____ Group No. _____

PART II: TO BE COMPLETED BY STUDENT'S MEDICAL PROVIDER
within the six months prior to departure

REVIEW OF SYSTEMS is negative _____ positive _____

Height: _____ inches Weight: _____ lbs. Pulse: _____ B/P: _____

	EXAMINATION	FINDINGS	RECOMMENDATIONS
	EYES		
	EARS		
	NOSE		
	THROAT		
	THYROID		
	RESPIRATORY		
	CARDIOVASCULAR		
	GASTROINTESTINAL		
	MUSCULOSKELETAL		
	NEUROLOGICAL		
	INTEGUMENTARY		

PERSONAL HISTORY SCREEN

Has your physical activity been restricted during the past 5 years? (give reasons and duration)

Have you consulted or been treated by clinics, physicians, or other practitioners within the past 5 years (other than routine check-ups)

In the last 5 years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional? If yes, explain here:

Have you been treated for chemical dependency? Yes No

Have you been hospitalized? If yes, give diagnosis and date.

Have you ever had a serious acute illness? If yes, give details.

Do you have my any chronic or recurrent illness? Any permanent/chronic injury or physical disability (give details)

Have you had any allergic reaction to prescription or over-the-counter medicines? (give details)

Have you had any allergic reaction to past immunizations? (explain)

Are you currently taking any medications (including oral contraceptives)? (list and give details)

Are you currently receiving antigen/immuno therapy injections or prescription medications for an allergy? (list)

Do you have any health requirements or dietary restrictions based upon religion? (explain)

Do you have any habits that might adversely affect your health? (explain)

Have you been diagnosed or treated for an eating disorder? (anorexia, bulimia nervosa) Yes No

PLAN

- _____ Reviewed general health education and risk reduction information
- _____ Discussed travelers diarrhea
- _____ Discussed high altitude
- _____ Discussed jet lag/motion sickness
- _____ Discussed insurance coverage in foreign country
- _____ Counseled to obtain immunizations

Yes _____ No _____ The above student is in good health and medically able to travel with the Carleton OCS program.

Yes _____ Contingent upon completing evaluation for _____ required prior to travel, which must be completed at least two weeks before departure, with WRITTEN DOCUMENTATION SUBMITTED to the OCS office before final approval of program participation is granted.

Yes _____ N/A _____ An appointment has been scheduled with a psychologist to discuss mental health issues, travel demands, and a treatment plan when traveling abroad.

	Counseled	Obtained
Hep A		
Hep B		
Typhoid		
Menomune		
Others (Rabies, yellow fever, Japanese encephalitis)		
Boosters (IPV, OPV, Td, Measles)		

Yes _____ N/A _____ We have developed a travel treatment plan for patient regarding chronic or recurrent illness.

Recommendations: _____

PROVIDER NAME: _____
(If stamp is used, please sign and date as well)

Organization: _____

Address: _____

Phone: _____ **Email:** _____

Provider's signature: _____ **Date:** _____