

HEALTH ASSESSMENT FORM

CARLETON COLLEGE OFF-CAMPUS STUDIES

One North College Street, Northfield, MN 55057

Phone: (507) 646-4332; Fax (507) 646-5614

PART I: TO BE COMPLETED BY STUDENT

A). Student/Family Information

Seminar Name _____ Term _____
Student Name _____ Class yr. _____ Gender _____ DOB _____
Home Address _____
Phone _____ E-mail address _____

Mother/Guardian Name _____ Home Phone _____
Address _____ Work Phone _____
Email Address _____

Father/Guardian Name _____ Home Phone _____
Address _____ Work Phone _____
Email Address _____

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 release of this information to authorized medical personnel 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 This release remains effective through the last day of the program and may be rescinded by me in writing at any time.

Student Signature _____ Date _____

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

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 _____ Telephone _____

Address _____ Policy No. _____ Group No. _____

PART II: TO BE COMPLETED BY STUDENT'S MEDICAL PROVIDER

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		

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:** _____