



Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 IHP Program: \_\_\_\_\_  Fall 20\_\_\_\_  Spring 20\_\_\_\_  Academic Year 20\_\_\_\_-20\_\_\_\_

The medical form must be completed by all applicants. Failure to submit the medical form on time or to answer all questions may jeopardize your participation in the program. Your participation depends on our review of your medical history and on any limitations that could affect your experience abroad. If you require special accommodations in order to complete the requirements of the program, please attach a separate letter of explanation.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Sex: \_\_\_\_\_ Age: \_\_\_\_\_

If you answer YES to any of the following questions, please provide details of the condition and the treatment. Please contact IHP if any conditions or treatments change before the start of your program.

1. Are you currently undergoing medical treatment?  
 No  Yes (explain)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Do you have any chronic medical conditions (e.g. asthma, diabetes, etc.)?  
 No  Yes (explain)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Are you currently taking any medication?  
 No  Yes (explain: medication name and dosage)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Is this medication for a temporary or ongoing condition?  
 What condition?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Please list all medications you will bring with you:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Do you have any allergies?  No  Yes  
 (If yes, explain below and indicate severity)  
 Food: \_\_\_\_\_  
 \_\_\_\_\_  
 Medicine: \_\_\_\_\_  
 \_\_\_\_\_  
 Other: \_\_\_\_\_

8. Please list any dietary restrictions/preferences and clarify the extent to which you can be flexible.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Have you ever been treated by a mental health practitioner?  
 No  Yes (explain)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12. Do you have or have you ever had an eating disorder?  
 No  Yes (explain)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

13. Do you have a history of drug or alcohol abuse?  
 No  Yes (explain)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician's Name: \_\_\_\_\_  
 Physician's Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Physician's Phone: \_\_\_\_\_  
 Physician's Fax: \_\_\_\_\_



Name: \_\_\_\_\_

14. Do you have any learning disabilities or physical impairments? No Yes (explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Have you had any surgical operations or been advised to have any? No Yes (explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Are you or might you be pregnant? No Yes (explain)

\_\_\_\_\_

18. Is there anything else about your health or medical history that may be a factor in an emergency? No Yes (explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Have you had any diseases or significant injuries within the last five years? No Yes (explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have scheduled an appointment on (date) \_\_\_\_\_ with my doctor to complete the Physician Medical Report.

I hereby verify that all of the information contained in the Medical Information Form and the Physician Medical Report form is accurate and complete. I acknowledge that any failure to provide accurate and complete information, including notification to IHP of changes in my health affecting the accuracy or completeness of the information contained in the aforementioned forms, may result in my dismissal from the program. I agree to notify IHP of any material changes in my health that occur prior to the start of the program.

**Permission for Emergency Medical Treatment and Authorization to Release Medical Records**

On rare occasions, an emergency requiring treatment in a hospital and/or surgery may develop. In most cases, administration of an anesthetic, treatment of an injury, or operation upon an individual cannot be done without consent of the patient. In order to prevent a dangerous delay in an emergency situation where IHP is either unable to contact my parent or guardian, or if I am unconscious or otherwise unable to give you my consent, I hereby authorize IHP's representative to secure whatever medical treatment is deemed necessary, including administration of an anesthetic and surgery.

As a participant in the International Honors Program (IHP), I hereby authorize the physician or other medical or mental health provider completing the Physician Medical Report form, together with any other physician or medical or mental health provider who has provided information to IHP in connection with my application or participation in the Program, to release any or all medical records or information pertaining to me to the International Honors Program. I also authorize the release by the International Honors Program of my medical records or other medical information pertaining to me to my parent or other designated contact person in the event of an emergency.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date