CONFIDENTIAL PHYSICIAN'S REPORT

TO STUDENTS: Please complete the top section and questions 1-10 and return the form directly to Off-Campus Study/Center for International Programs in 101 McGregory Hall. OCS will forward the form to the Student Health Services for the doctor's review. DO NOT TAKE THE FORM TO YOUR FAMILY DOCTOR OR TO STUDENT HEALTH SERVICES.

Do not leave any blank spaces (you may write **"None"** where appropriate). *You have already been accepted to the Off-Campus program and the information you submit will be used solely as an aid to providing necessary health care.* Student Health Services will review the forms and make recommendations about participation. This form will be available to the Program Director. It will *not* be released to anyone else without your prior knowledge and consent. Please be aware that your medical records at Colgate University are confidential and will remain on campus while you are away.

Name _____ Date _____
(Last) (First) (MI)

Off-Campus program _____ Fall Spring 20_____
(circle one)

Destination of Trip_____ Travel Dates: from_____ to _____

NOTIFY THE PROGRAM DIRECTOR AND THE DIRECTOR OF OFF-CAMPUS STUDY IF YOU ARE EXPOSED TO ANY COMMUNICABLE DISEASES (E.G. CHICKEN POX, HEPATITIS, ETC.) AND/OR HAVE ANY ILLNESSES, INJURIES OR OTHER CONDITIONS AFTER COMPLETION OF THIS FORM, WHICH MUST BE ON FILE IN THE OFF-CAMPUS STUDY OFFICE BEFORE YOU LEAVE.

1. **OPERATIONS** – Please list dates and results.

2. **CHRONIC ILLNESSES** – Please indicate type, duration, treatments, limitations, and/or ongoing health needs.

3. **HOSPITALIZATIONS** – Please indicate type duration, treatments, limitations, and/or ongoing health needs.

4. **RECENT ILLNESSES** – (within the past year) – Please indicate type, duration, treatments, limitations, and/or ongoing health needs.

5. **ALLERGIES** – Please list all allergies, including those to food, medications, insect bites or bee/wasp stings, environmental exposure, etc. Please indicate if you are taking any allergy medicines (tablets, inhalers, injections—either over-the-counter and/or prescription, etc.)

6. **PHYSICAL AND/OR LEARNING DISABILITIES** – Please indicate type, duration, treatments, limitations and/or ongoing needs. Also, if you receive accommodation on campus for a physical and/or learning disability, please describe the nature of the accommodation.

7. **DIETARY RESTRICTIONS** – If so, please indicate type.

8. **OTHER** – Please answer yes or no (and further describe if yes)

a) Treatment or problems associated with drug/alcohol/chemical abuse or dependency).

b) Psychiatric/Psychological treatment or counseling.

c) Eating Disorders (anorexia, bulimia, compulsive overeating).

9. **MEDICATIONS** – (prescription and/or over-the-counter) – Please list names and health problems being treated. ***REMEMBER** you will need to bring with you a supply of any medications for the entire duration of your stay off-campus.

10. Do you have, or have you had, any other health issues, conditions or problems which we should be aware of? If so, please explain.

The medical information provided above is complete and true to the best of my knowledge. I recognize that falsification or omission of information may jeopardize my own health and safety as well as that of other group members and could be grounds for non-participation (dismissal from the group).

Student Signature _____ Date _____

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MEDICAL APPROVAL – TO BE COMPLETED BY THE STUDENT HEALTH CENTER

"I have reviewed this applicant's records and I believe that his/her physical and mental health will permit him/her to participate in this particular event off campus both domestically and abroad. Attached is a copy of this applicant's immunization record."

PHYSICIAN'S COMMENTS:

Physician's Signature _____ Date _____

Merrill Miller, MD Colgate Student Health Center
13 Oak Drive, Hamilton, New York 13346
Tel: 315-228-7750