SCHOOL OF PUBLIC AND ENVIRONMENTAL AFFAIRS
INDIANA UNIVERSITY

Medical History Form

(PLEASE PRINT)

Name: _____ Summer Program: _____

Social Security Number (optional): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Please provide below information that will help our staff overseas obtain medical assistance for you in the case of accident or illness. Language barriers and incomplete medical records can delay treatment. It is therefore important that you provide any information that might be relevant in a medical emergency.

1. Are you currently receiving, or have you recently received any medical or psychological care of which you want us to be aware in case of an emergency? If so, describe fully:
   _____
   _____
   _____
   _____

2. List any major surgeries: _____
   _____

3. List any other on-going physical or emotional conditions which might require treatment abroad, or that might be exacerbated by changes in climate, diet or exercise. What treatment is recommended?
   _____
   _____
   _____
   _____

4. List all current medication: _____
   _____
   _____

5. What medications or other substances are you allergic to? _____

6. Are you on a medically restricted diet? If so, give details: _____
   _____

7. Important dietary preferences (i.e. only eat poultry, do not eat red meat or pork, aversion to mayonnaise): _____
   _____

8. SPEA Abroad programs endeavor to provide reasonable accommodations for students with *documented* disability conditions (e.g., physical, learning, etc.). If you are receiving disability-related accommodations at IU or anticipate needing them at your overseas site, attach documentation confirming the disability and information about accommodations currently provided at IU (e.g., a letter from Disabled Student Services). Provide details relevant to your request for accommodation(s) abroad on a separate sheet.

   (If you choose not to disclose disability related needs prior to the program, IU will not be able to assist you in arranging special accommodations.)

9. Blood type (if known): _____

10. Date of last Tetanus shot: _____

11. Date of MMR: _____

12. Date of Hepatitis B: _____

13. Do you have a physician who should be consulted in case of an emergency? If so, list below:

    Physician's name_____ Phone (____)_____

    Address: _____ City _____ State: _____ Zip _____

14. Do you have a dentist who should be consulted in case of an emergency? If so, list below:

    Dentist's name _____ Phone (____) _____

    Address: _____ City _____ State: _____ Zip _____

15. Do you have an eye doctor who should be consulted in case of an emergency? If so, list below:

    Optometrist's name _____ Phone (____) _____

    Address: _____ City _____ State: _____ Zip _____

16. Primary Insurance Information:

    Provider: _____ Subscriber Name: _____

    Identification Number: _____ Plan Number: _____ Group Number: _____

    Insurance contact telephone number for coverage while traveling: _____

17. Emergency Contact Information:

    Name: _____ Relationship: _____

    Address: _____ City _____ State: _____ Zip _____

    Home Phone: _____ Cell Phone: _____ Work Phone: _____

    Additional Phone Numbers: _____

I grant IU, its employees, agents and consortium partners, full authority to act in an attempt to safeguard and preserve my health and safety during my participation in the program abroad, including authorizing routine or emergency medical treatment on my behalf and at my expense and returning me to the United States at my own expense.

_____ _____

Signature *Date*

06/11