

**Office of International Programs and Services**

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**Student Health Review**

\*\*\* **PLEASE PRINT** \*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Phone: |  |
| Evergreen ID: |  | Birthdate: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. Do you have any potentially life-threatening conditions we should be aware of? | | Yes |  | No |  |
| If yes, Please explain: |  | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Per state law and college policy, you are required to have medical insurance when studying abroad. | | | | |
| Insurance Company: |  | | 24-hour Phone: |  |
| Policy Number: |  | | Medical ID Number: |  |
| Emergency procedure preferences, if any: | |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Medical History of Participant: Please answer the following questions to the best of your knowledge. | | | | | | |
| No | Yes |  | | | | |
|  |  | Are you taking any required medication? If yes, list the medication and dosage: | | | |  |
|  |  | Are you currently under the care of a physician, practitioner, counselor or psychologist at this time? | | | | |
|  |  | If yes, describe: | |  | | --- | |  | | | | |
|  |  | Do you have any physical complaints, chronic illness, or psychological problems at this time? | | | | |
|  |  | If yes, describe: |  | | | |
|  |  | Have you had injuries in the past? (back, knee, shoulder, elbow, etc.) | | | | |
|  |  | If yes, describe: | |  | | |
|  |  | Are you on a special diet? If yes, specify: | | |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. Do you have or have you ever had: | | | | | | |
| No | Yes |  | | | | |
|  |  | Diabetes? If yes, list your insulin medication and dosage: | | | |  |
|  |  | Seizures? | | | | |
|  |  | Asthma? | | | | |
|  |  | Allergies? Please specify: | |  | | --- | |  | | | | |
|  |  | Allergies to bee stings? Describe reaction: | | |  | |
|  |  | Do you carry medication? Describe: | | |  | |
|  |  |  | | |  | |
| 1. Please describe any other medical condition: | | | |  | | |
|  | | | |  | | |

I approve of emergency care for myself, or the above minor, under the direction of the event leader or

consulting doctor, if I am unable to make my wishes known.

I DO NOT wish to grant medical consent.

I have filled out this form to the best of my knowledge. I have consulted a physician if I have any medical risks.

If traveling independently, I will keep a copy of this record with my important travel documents.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_