WCSU Student Medical History Form
Costa Rica 2016

Last Name:	
First Name:	
WCSU ID#:	
Dr.'s Name:	
Complete Mailing Address:	
Dr.'s Phone #:	
Blood Type:	
Height:	
Weight:	

Your candid responses to the questions following will help Western Connecticut State University assist you in safeguarding your health while you are abroad. This information is not a criterion for selection. However, please be aware that facilities or services in your host country may not be comparable to those in the U.S.

In order to provide you with relevant information about the services of your host country, it is in your best interest to complete this form thoroughly and accurately. *Your responses will be held in strict confidence by Western Connecticut State University* and will be shared only with medical personnel if consultation is necessary.

If you answer YES to any of the following questions, please provide details of the condition and the treatment you received or are continuing to receive on a blank sheet of paper. Write the number of the question beside each response. Please contact us if any conditions or treatments change before the start of your program.

1) Are you currently under medical treatment? ❒ NO ❒ YES

2) Do you have any chronic medical condition (e.g. Asthma, Diabetes, etc.)?
❒ NO ❒ YES

3) Do you have any allergies (animals, food, environment, medication, etc.)?
❒ NO ❒ YES

4) Have you had any diseases or significant injuries within the last five years?
❒ NO ❒ YES

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5) Have you had any surgical operations or been advised to have any? ❒ NO ❒ YES

6) Are you currently taking any medication? ❒ NO ❒ YES
If yes, please list: _____
_____

7) Do you have any dietary restrictions or preferences (e.g. vegetarian, diabetic, food allergies, etc.)? If yes, please explain. ❒ NO ❒ YES

8) Have you been treated in the last 24 months for a mental, emotional nervous disorder or depression? ❒ NO ❒ YES

9) Do you or have you ever had an eating disorder? ❒ NO ❒ YES

10) Do you have a history of drug or alcohol abuse? ❒ NO ❒ YES

11) Are you currently under treatment for drug or alcohol abuse? ❒ NO ❒ YES

12) Do you have any physical impairment, learning disability, or other condition that might restrict your mobility or require special facilities or assistance while abroad? ❒ NO ❒ YES

13) Are you pregnant or do you have any reason to suspect that you might be? ❒ NO ❒ YES

14) Do you have any Neurological disorders (epilepsy, multiple sclerosis, etc.)? ❒ NO ❒ YES

15) Have you ever been treated for cancer, tumor or other malignancy? ❒ NO ❒ YES

16) Do you have an immunodeficiency disease (AIDS, Lupus, Scleroderma, etc.)? ❒ NO ❒ YES

17) Do you have diabetes? ❒ NO ❒ YES

18) Do you have frequent or severe attacks of hay fever, allergy or difficulty breathing? ❒ NO ❒ YES

19) Do you have a history of blackouts or fainting (full/partial loss of consciousness)? ❒ NO ❒ YES

20) Do you frequently suffer from motion sickness (carsick, airsick, etc.)? ❒ NO ❒ YES

21) Do you have a history of bleeding or other blood disorders? ❒ NO ❒ YES

22) Do you sleepwalk? ❒ NO ❒ YES

23) Do you smoke? ❒ NO ❒ YES

24) Do you have any other health condition that might limit your participation in this program?
❒ NO ❒ YES

Authorization Statement

I hereby authorize the release of information from my medical history upon the request of Western Connecticut State University. I further authorize the release of information by Western Connecticut State University to its administrative centers and to cooperating or affiliated foreign institutions. I certify that the information on this Medical History Form is true and correct, and I will notify Western Connecticut State University hereafter of any relevant changes in my health that occur prior to the start of the program. I understand that this information will be used only for the purposes for which it was prepared.

I hereby release and forever discharge Western Connecticut State University, its officers, agents, and employees from all claims, rights, demands, actions, obligations, and causes of action of any and every kind, nature and character, whether known or unknown, which I may have arising from or in any way connected with the rendering or provision of medical care or services or treatment on my behalf while living abroad as a participant in Western Connecticut State University's Course Abroad Program and I hereby agree to hold harmless it's officers, agents, and employees from any liability resulting from or arising in connection with the rendering or provision of medical care or services or treatment on my behalf while living abroad as a participant in the Western Connecticut State University Course Abroad Programs.

_____ _____

STUDENT SIGNATURE DATE

_____ _____

DOCTOR'S SIGNATURE DATE

(Return to: Theodora Pinou, Western Connecticut State University, 240 Science Building, Danbury, CT 06810 Fax: 203-837-8875
OR
Ms. Lisa Taylor, Department of Biological and Environmental Sciences, Science Building, 2nd Floor)