

## Spain Study Abroad

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Purdue University Calumet  
Department of Foreign Languages & Literatures  
2200– 169<sup>th</sup> Street - Hammond, IN 46323  
PHONE: (219) 989-2632 FAX: (219) 989-2165

### Medical Information Form

#### Instructions to study abroad student:

- Please complete sections I, II and III
- If you answer “Yes” to any questions in Section II, make sure to give details in the space available. If you need more space, attach another sheet.
- If you answer “Yes” to questions 2 or 3 in Section III, the physician who is primarily responsible for your condition will need to complete Section IV. A visit to your physician is not required unless your doctor considers it necessary to update your medical status.

#### Medical Report Review

An applicant will not be rejected due to either his/her physical or emotional condition unless it is of such nature as to prevent successful participation in the program, unless medical care for a patient’s medical problem is not available in the country in which the applicant will study, and/or the living and environmental conditions to which the applicant could be exposed would present a risk to the health of the individual. A health record is confidential and accessible only to health personnel and the staff of the studyabroad office and the individual program to which the applicant has applied. Information regarding an applicant’s health, however, is important in anticipating and dealing with health problems which may arise during the student’s stay abroad.

#### Future Medical Problems

Should you develop significant health problems between the time you have completed this form and commencement of the program, which may influence your participation in the program, it is your responsibility to notify the study abroad office at Purdue University. A medical report should accompany this notification  
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### Medical Information Form

#### I. General Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_  
Permanent Address \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
*City State Zip Code*

Study Abroad Program: \_\_\_\_\_

**II. Personal History--to be completed by the student:** Have you ever had or do you now have (check yes or no):

	Yes	No		Yes	No
Chicken Pox			Chronic Skin Problems		
Hepatitis			High Blood Pressure		
Epilepsy			Anemia		
Infectious Mononucleosis			Irregular or Rapid Heart Beat		
Fainting Spells			Anxiety Reactions		
Tuberculosis or contact with Tuberculosis Migraine Headaches			Pain or Pressure in the Chest		
Malaria Endocrine Disorder(s)			Allergies to Medications		
Heart Problems			Asthma		
Diabetes Mellitus			Operations(s)		
Significant Allergic Reaction(s)			Serious Accident(s)		
Chronic or Recurrent Gastrointestinal Problems			Physical Handicap(s) (please elaborate)		
Kidney Problems			Are you currently taking any medications (list)		
Hernia			Other		

Give details of those items checked "Yes" using the back of this page and adding additional sheets if necessary. Indicate problem, diagnosis if known, and whether recovery has been complete or if still under treatment.

**III. Current Medical History**

1. Have you been in good health during the past 12 months? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Do you have any significant chronic medical conditions requiring on-going medical supervision and treatment, or have you had in the past any significant condition which is currently in remission? (Ex. diabetes, heart problems, chronic or recurrent gastrointestinal disorder, seizure disorder, treatment for cancer, bleeding disorder, etc.)  
Yes \_\_\_\_\_ No \_\_\_\_\_
3. Are you currently receiving, or have you received in the past two years, counseling for *any* emotional problem, drug addiction, alcoholism, psychiatric condition or eating disorder? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Do you have any dietary restrictions or food allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

\*If you answered yes to #2 or #3, the physician primarily responsible for your care must fill out the following Physician's Report Form.

**I certify that I have read and understand the Medical Information Form, that all responses made on this Medical Information Form are true and accurate, and that I will notify the study abroad office hereafter of any relevant changes in my health that occur prior to the start of the program.**

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_  
(mm /dd/ yy)

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**Physician's Report for**

**(Student's name):** \_\_\_\_\_

The applicant has indicated a chronic and/or recurrent health problem. You are being asked to evaluate the physical and/or mental health of the above-named applicant for participation in a study abroad program. The availability of medical services in the country (ies) that the applicant will be traveling should be considered. If needed, please use the space below.

Diagnosis

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Medications and Dosage

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Stability of condition over the past two years

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Recommendations for care of this individual

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Is this individual capable of participating in the program to which he/she is applying?

Yes \_\_\_\_\_ No \_\_\_\_\_

Signature \_\_\_\_\_ Telephone: \_(\_\_\_\_)\_\_\_\_\_

Address:

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