WOFFORD

Medical Form

Please complete the information below. Participation in the travel/study project is contingent upon the Office of International Programs receiving a completed medical form, among other documents. Your healthcare provider should complete this form based on an examination within six months of the project departure date. Please submit to your project sponsor by the sponsor's deadline. Project sponsors should submit all forms to the Interim Coordinator by December 7, 2012.

STUDENT'S NAME _____ ☐ ☐
Last First Middle Male Female

ADDRESS _____

W NUMBER _____ DATE OF BIRTH _____ AGE _____

PARENT/GUARDIAN _____
Name Relationship to Student

TELEPHONE Home (_____) _____-_____ Work (_____) _____-_____ Cell Phone (_____) _____-_____

Please mark the project in which you are enrolled:

X	Project	Sponsor(s)	Activities
	401 Broadway- Musical Theatre & the Story of America	Jones/Cathey	Walking
	414 Life in Namibia & Cape Town	Davis/Moeller	Walking, hiking
	416 SCUBA Dive Bonaire	Kusher	Walking, swimming, SCUBA
	417 Europe through the Back Door: Malta, Monaco, Vatican City, San Marino	Swicegood/Brunow	Walking, hiking, swimming
	421 Harry Potter's Britain	Lefebvre/Ballance	Walking
	422 Rites of Passage: India and Nepal	Schmunk/Efurd	Walking
	423 Belize: An Ecotourism Adventure	Smith	Walking, hiking, swimming, canoeing/kayaking
	425 Baja Sea-Kayaking Adventure	Ware	Walking, hiking, swimming, canoeing/kayaking
	426 45 Years Later: Wofford Returns to Prague	Grinnell/Byrnes	Walking
	427 World War II and Its Aftermath	Waidner/Machovec	Walking
	429 Spain and Morocco: Cultural Connections	Chalmers/Hitchmough	Walking
	430 Buenos Aires, the Glaciers of Patagonia, and the End of the World	Reid/Akers	Walking

PERSONAL MEDICAL HISTORY OF STUDENT
To Be Completed by/with a Healthcare Provider (this can include Wofford College Health Services staff)

ALLERGIES:
Drug Allergies: _____ Food Allergies: _____
Medications or injections for the above allergies: _____
***HEALTH HISTORY:** Place a checkmark in the appropriate box if the patient has any of the following conditions:

	Arthritis		Eye Injury/Disease		Migraine Headaches		Sexually Transmitted Disease
	Asthma		Frequent Headaches		Mononucleosis		Skin Problems
	Back Problems		Heart Murmur		Neurological Disorder		Thyroid Problem
	Blood Disorder/Anemia		Hepatitis (Jaundice)		Pneumonia		Ulcer/Stomach or Duodenal
	Bone/Joint Problem		Hernia		Recurrent Bronchitis		Urinary Tract Infections
	Cardiac Problem		High Blood Pressure		Recurrent Sinusitis		Other:
	Chest Pain/Shortness of Breath		Inflammatory Bowel Disease		Rheumatic Fever		
	Chicken Pox		Kidney Stone/Disease		Seizures/Epilepsy		
	Diabetes		Malaria		Severe Menstrual Cramps		

PLEASE PROVIDE DETAILS OF ALL THE CONDITIONS CHECKED ON THE PREVIOUS PAGE: _____
_____
_____

Hospitalizations, treatments, surgeries (including outpatient), or procedures (include dates and doctors): _____
_____

Healthcare Provider for above conditions (if differs from provider completing form): _____
Address: _____
Phone: _____ Fax: _____

Is the student currently on a restricted diet? Please explain, and mention vegetarianism if applicable. _____
_____

All Wofford College students are required to have had the following immunizations before enrolling as new students: MMR x2, Tetanus-Diphtheria, Polio, Tuberculosis Screening, and Hepatitis B series. **Please list any additional immunizations required or recommended for the student's overseas destination, if applicable.** Please indicate below if your office has administered these and the date.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

SPECIAL ACCOMMODATIONS:
Does the student have any speech, hearing, or eyesight impairment that might affect participation in the program? _____
_____

Does the student have any physical disability that might cause hardship through change of diet, carrying luggage or strenuous travel?
_____

Does the student have any learning disabilities? If so, are special accommodations required? _____
_____

MENTAL HEALTH HISTORY: Place a checkmark in the appropriate box if the patient has any of the following conditions:

	Anxiety/Panic Attacks		Drug and/or Alcohol Dependency		Severe sleep disorders
	Behavioral Disorders		Eating Disorders		Unusual degrees of anxiety, fear, or guilt
	Depression		Mood Swings		Other (specify):
	Difficulty with authority figures or peers		Phobias		

PLEASE PROVIDE DETAILS OF ALL THE CONDITIONS CHECKED ABOVE (attach additional pages as necessary):
_____
_____
_____

Medications: Past: _____ Current: _____

For the examining physician: To your knowledge, are there any predisposing medical, surgical, or emotional factors that may, under stress during the project, present a need for immediate therapy while abroad? Please explain (attach additional pages as necessary).
_____
_____

How long have you known the student? _____ Date of the student's most recent examination: _____/_____/_____
What is the student's general state of health? _____ Excellent _____ Good _____ Fair _____ Poor
What is the student's general state of mental health? _____ Excellent _____ Good _____ Fair _____ Poor

I believe _____ to be physically and emotionally able to participate in the off-campus travel/study
Name of Student
project indicated above.

Completed by:
Provider's name: _____ Signature: _____
Address: _____
Tel: _____ Fax: _____