Medical Form

Please complete this form and return it to the International Education Center

We ask for this information so that our staff will know in advance of special medical conditions you may have, rather than learning about them in a crisis. Also, in the event of serious injury or illness, this form provides emergency medical personnel with a useful medical history. After reviewing this form, the college may contact you to discuss whether the trip will be safe and enjoyable for you considering your medical history.

We will keep the information on this form confidential. It will be seen only by staff, medical personnel, or others who know and understand its confidential nature. The form will be retained along with your liability waiver for a period of time following the trip, after which it will be destroyed.

General Information

Name: _____ **Gender:** ☐ Male ☐ Female
FAMILY/LAST FIRST MIDDLE

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home: (____) _____ **Work:** (____) _____

E-mail address: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Resting Pulse:** _____

Emergency Contact: _____ Relationship to applicant: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

If the above person is unavailable, please notify: _____ Relationship to applicant: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

Medical Insurance

Participants in Santa Monica College programs will be automatically enrolled in the iNext Travel Insurance. You should carefully review the coverage offered by this Policy. If the coverage is not adequate to meet your needs, you should secure additional insurance at your own expense.

Please check if you have had

☐ Allergy (please specify)
- ☐ Hay Fever
- ☐ Bees/wasps
- ☐ Pet/animal dander
- ☐ Foods _____
- ☐ Other _____

☐ Eye problems
☐ Hearing loss
☐ Anemia
☐ Bleeding/Clotting
☐ Bladder/kidney problems
☐ Cancer or Leukemia

☐ Stomach Ulcer
☐ Heart problems
☐ Back problems
☐ Painful swollen joints
☐ Abdominal pain
☐ Chronic indigestion, diarrhea

☐ Immune System problems
☐ Impaired use of any limbs
☐ Epilepsy (seizures)
☐ Recurrent dizziness/faintness
☐ Severe Headaches

Comment below on any condition(s) that you have checked above (attach additional pages if necessary):

_____

Student Name: _____

Name of Program: _____

Medications

Please list all prescription, over-the-counter, and natural medications you are taking. ***Use a separate sheet if necessary.***

Medication Name	Dosage	Frequency	Side Effects (known & potential)	Reason for Taking

Medical History

Please complete the following, adding additional paper if necessary. DO NOT LEAVE ANY QUESTION BLANK. If you answer "Yes" to any of the following questions, please provide additional detail.

- Have you consulted or been treated by clinics, physicians or other practitioners within the past two years (other than routine check-ups)? ☐ Yes ☐ No ***If yes, please explain.***
- Have you ever been hospitalized or had a serious acute illness? ☐ Yes ☐ No ***If yes, please explain.*** Do you have a chronic medical condition or recurrent illness? Any permanent injury or physical disability? ☐ Yes ☐ No ***If yes, please explain.***
- Have you had any allergic reaction to past immunizations, prescription, or over-the-counter medicines? ☐ Yes ☐ No ***If yes, please explain.***
- Do you have a history of asthma or other respiratory ailment? ☐ Yes ☐ No ***If yes, please explain.***
- Are you currently taking any medications (including antigen/immunotherapy allergy injections)? ☐ Yes ☐ No ***If yes, please explain.***
- Do you have any health requirements or dietary restrictions? ☐ Yes ☐ No ***If yes, please explain.***
- In the last two years, have you consulted or been treated by a psychiatrist, clinic psychologist, drug/alcohol counselor, or other mental health professional for any mental, emotional, or psychological conditions including eating disorders and substance abuse? ☐ Yes ☐ No ***If yes, please explain.***
- Recent exposure to infectious diseases? ☐ Yes ☐ No ***If yes, please explain.***
- Do you have asthma? ☐ Yes ☐ No ***If yes, please list any medications above.***
- Do you have diabetes? ☐ Yes ☐ No ***If yes, please list any medications above.***
- Do you have a history of high blood pressure? ☐ Yes ☐ No ***If yes, please explain on a separate sheet.***
- Do you have any problems with your eyes or vision? ☐ Yes ☐ No ***If you wear prescription glasses or contacts, we recommend bringing a spare set.***
- Do you have any problems with your hearing? ☐ Yes ☐ No ***If yes, please explain.***
- Are you pregnant? ☐ Yes ☐ No
- Do you have any bone, joint, or muscle problems? ☐ Yes ☐ No ***If yes, please explain on a separate sheet.***
- Have you ever had a seizure? ☐ Yes ☐ No ***If yes, please explain on a separate sheet.***
- Have you ever experienced altitude problems? ☐ Yes ☐ No ***If yes, please explain on a separate sheet.***

Student Name: _____

Name of Program: _____

- Do you have any other medical issues that might affect your participation in this trip? ☐ Yes ☐ No ***If yes, please explain:*** _____

_____

- The trip may require vigorous activity, extended walking or hiking, and other physically and mentally demanding exertion in isolated areas without medical facilities, medical providers, or means of contacting rescue or medical personnel. Please state below all physical or mental limitations and restrictions of which you are aware:

If you have no such limitations, please initial here: _____

_____

_____

Immunization Record

Indicate the most recent date. The following immunizations are not required for this program; however, please provide this information for your medical history. Check the Center for Disease Control and Prevention (CDC) website (http://www.cdc.gov/) for recommended immunizations for your destination.

Tetanus/diphtheria/pertussis (Td or Tdap) _____

Polio (certain programs in Africa & Asia) _____

Meningitis (certain programs in Africa) _____

Measles, Mumps, Rubella (MMR #1) _____

Measles, Mumps, Rubella (MMR #2) _____

Other Immunizations: _____

If Individual:

Measles (Rubeola) _____

Mumps_____

Rubella (German measles) _____

- **Tetanus:** It is strongly advised that you are inoculated against this fatal disease and you obtain a booster within every 10 years. The date of your most recent tetanus inoculation or booster: _____/_____/_____

Physical Examination

Date of most recent physical: _____/_____/_____ Physician's name: _____

Address: _____ Phone Number: _____

Physician's signature (if required): _____

Student Name: _____

Name of Program: _____

Authorization for Treatment

In the event of an emergency abroad, Santa Monica College may notify my emergency contact(s). In the event that I need medical care, hospitalization or surgery while participating in the program, I understand that every effort will be made to contact the emergency contact(s) listed on this form. In the case that my emergency contact(s) cannot be reached and an immediate decision about care or treatment needs to be made, I authorize Santa Monica College, through its representatives, to secure any necessary treatment. Santa Monica College may, but is not obligated to, take any actions is considers to be warranted under the circumstances regarding my health and safety.

If coverage is not provided through my insurance program, I understand that such treatment shall be solely at my expense, and I shall reimburse Santa Monica College or its representatives for any expenses that they might incur on account of my condition or treatment. I release, discharge, indemnify and agree to hold harmless Santa Monica Community College District, its Board of Trustees, officers, agents, representatives, employees, volunteers, staff members, campus directors, chaperones, group leaders, from any liability which may result from authorizing any medical treatment and/or medication for me.

I certify that all responses on this Medical Form are true and accurate.

Please notify College immediately if any information on this form changes.

CHANGE OF STATUS: You are responsible for notifying Santa Monica College International Education Center immediately of any changes in your health history prior to your departure or while on the program.

Program Name: _____ **Dates:** _____

Signature (required): _____ **Date:** ____/____/____

Print Name: _____