WILSON COMMUNITY COLLEGE

WE'VE GOT YOUR FUTURE

Travel Abroad Program

Medical History Form for International Travel

Full Name: _____
Last Name (Print) First Name Middle Name

Birth Date: _____

Instructions: Please complete this health history form to the best of your ability. It is used only to help arrange special accommodations when necessary or to assist you in emergencies. (This information is kept confidential and shared only when necessary as outlined in the release statement at the end of this form.)

My general health is: ( ) Excellent ( ) Good ( ) Fail ( ) Poor

Allergies:
( ) Penicillin ( ) Aspirin ( ) Bee stings
( ) Nuts ( ) Eggs
( ) Environmental (give details) _____
_____
( ) Other (give details) _____
_____

Diet:
( ) Regular ( ) Vegetarian
( ) Restricted Diet (give details): _____
_____

Medications (List names of all medications and dosages you are currently taking):

( ) Inhalers: _____
( ) Birth Control: _____
( ) Psychological medications: _____
( ) Insulin injections/pump: _____
( ) Seizure medications: _____

( ) Other medications prescribed for medical or mental health conditions (give details):

_____

Medical History: Hospitalization (give dates and type) _____

Surgery (give dates and type): _____

Health History:

( ) Cancer/tumors
( ) Ulcer/stomach problem
( ) Hepatitis/jaundice
( ) Headaches
( ) Thyroid problems
( ) Alcohol
( ) Other: _____
( ) Back/joint problem
( ) Anemia/bleeding disorder
( ) High Blood Pressure
( ) Heart Problems
( ) Eating disorder
( ) Other substance abuse

Please check below any medical or psychological conditions that have required psychological care within the past 5 years:

( ) Depression
( ) Eating Disorder
( ) OCD
( ) PTSD
( ) Suicidal Ideation
( ) Panic Disorder
( ) Anxiety Disorder
( ) Bipolar Disorder
( ) Anger Management
( ) Suicide Attempt
( ) Self Harm
( ) Conduct Disorder

( ) Other (Please List) _____

Health Insurance Provider: _____

Policy Number: _____

PLEASE ATTACH A COPY OF YOUR PAID INSURANCE TO THIS FORM

Release of Information: I understand that the information included in this health history may be shared with other Health and Wellness Centers and/or Counseling Services, support services or medical providers for the purpose of protecting my health during the period of my participation in the Travel Abroad Program, or in the case of a medical emergency abroad.

Signature: _____

_____, 20_____
Date

Parent/Guardian: _____
Co-signature of parent or guardian if student is under 18 years of age

_____, 20_____
Date