Canisius COLLEGE
Where leaders are made

Office of Campus Ministry
2001 Main Street l Buffalo, NY 14208
Old Main 207 | phone 716-888-2420
fax 716-888-3144 | email firestol@canisius.edu

Medical Clearance Form

for students participating in an International Service-Immersion Experience

Name: _____ **Trip: _____**

I verify that all medical and psychological information I have provided is complete and accurate. I will notify Campus Ministry hereafter of any changes in my health that occur prior to my departure for this trip. I understand that Campus Ministry will keep this information confidential.

_____

Signature of Student (Required) **Date (mm/dd/yy)**

Medical History

Please check box if you have ever had any of the following conditions.

Infectious Disease
□ Chicken Pox
□ Infectious Mononucleosis
□ Rheumatic Fever
□ Scarlet Fever
□ Tuberculosis
□ Malaria

Eyes, Ears, Nose, Throat
□ Wear glasses/contact
□ Other Visual problems
□ Hearing Loss/Deafness
□ Seasonal Allergies
□ Recurrent Sinus Infection
□ Recurrent Ear Infection
□ Recurrent Nose Bleeds

Cardiopulmonary
□ Chest pain with exercise or exertion
□ Syncope or Near Syncope
□ Excessive exertional or unexplained
□ shortness of breath with exercise
□ Excessive exertional or unexplained
□ fatigue with exercise
□ Heart Murmur
□ Elevated blood pressure
□ Mitral Valve Prolapse
□ Rheumatic Heart Disease
□ Heart Palpitations or Irregular beat
□ Elevated cholesterol
□ Marfan Syndrome
□ Congenital Heart Defect
□ Asthma
□ Pneumonia/Bronchitis

G-I
□ Reflux/GERD
□ Ulcer
□ Pancreatitis
□ Gall Bladder Disease
□ Hepatitis Type: _____
□ Hernia
□ Rectal Bleeding
□ Irritable Bowel
□ Crohn's Disease
□ Ulcerative Colitis
□ Hemorrhoids

Genitourinary
□ Cystitis/Bladder Infection
□ Blood in Urine
□ Kidney Infection
□ Chronic Kidney Disease
□ Kidney Stones
□ Sexually Transmitted Disease

Female
□ Pelvic/Vaginal Infections
□ Pregnancy
□ Breast Lump
□ Painful periods
□ Irregular periods
□ Heavy flow
□ Abnormal PAP smear

Male
□ Testicular Lump
□ Testicular Torsion
□ Undescended/absent testicle
□ Hydrocele or Varicocele

Musculoskeletal
□ Arthritis
□ Joint Injury
□ Bone Fractures
□ Scoliosis
□ Back Pain/Problems
□ Osgood-Schlatter
□ Tendinitis
□ Other Musculoskeletal Disorders

Hematologic/Oncologic
□ Anemia
□ Sickle Cell trait/disease
□ Leukemia/Lymphoma
□ Hemophilia
□ Immune Deficiency
□ Cancer

Neurologic
□ ADD/ADHD
□ Seizure Disorder
□ Migraine Headaches
□ Tension Headaches
□ Concussion
□ Head Injury with Loss of Consciousness
□ Other Neurological Disorders

Skin
□ Eczema
□ Acne
□ Hives
□ Chronic rash
□ Tattoos/ Piercings
□ Other:_____

Metabolic
□ Diabetes Mellitus
□ Thyroid Disorder

Mental/Emotional
□ Anger Management
□ Eating Disorder
□ Drug/Alcohol Dependency/Abuse
□ Depression
□ Panic/Anxiety Disorder
□ Trouble sleeping
□ Bipolar Disorder
□ Mood Disorder
□ Obsessive Compulsive Disorder
□ Schizophrenia
□ Deliberate self harm
□ Previous psychiatric hospitalization
□ Other: _____

Other
□ Anaphylactic Reaction
□ Serious Accident/Injury
□ Loss of paired organ:
  □ Kidney
  □ Ovary
  □ Eye
  □ Testicle
  □ Other: _____

Other important medical history:

_____

_____

Do you use tobacco?
□ No □ Yes – packs/day_____

Do you drink alcohol?
□ No □ Yes – amount/week_____

Allergies: □ None
□ Allergic to medications
□ Allergic to X-ray dyes
□ Allergic to food/insects/ environmental
Please list all:
_____
_____

Surgeries: □ None
□ Appendectomy
□ Hernia repair
□ Mole Removal
□ Ear Tubes
□ Wisdom Teeth Extraction
□ Tonsils/Adenoids
□ Other: (specify below)
_____
_____

Medications (including vitamins and supplements): □ None
_____
_____
_____

Additional information you wish to share about your health:
_____
_____
_____

To the attending physician

Is this student cleared for 2-3 weeks of international travel that can be at times rustic, rural, hot and involve strenuous physical and emotional experiences?

□ Yes/ Unlimited activity and fit for travel □ No/Limited activity Reason:_____

Additional comments / Recommendations:_____

I have reviewed the medical history of the student noted above and it is accurate, full and complete to the best of my knowledge (Please date your signature.)

_____

Signature of Health Care Provider **Date (mm/dd/yy)**

_____

Print Name of Healthcare Provider **Address** **Phone** **Fax**