LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT.

WELLNESS CENTER FOR HEALTH AND COUNSELING
1419 SALT SPRINGS ROAD | SYRACUSE, NY 13214 | WWW.LEMOYNE.EDU
Health 315-445-4440 | Counseling 315-445-4195

MEDICAL REPORT

Le Moyne College Travel Abroad Program

To be completed by your Health Care Provider, Urgent Care Provider or the Le Moyne College Health Center

Please return this form to the Program Director by:_____

Name: _____ Date: _____
(Last) (First) (Middle)

Program Name & Destination: _____ Travel Dates: _____

Phone: _____ email: _____

TO THE STUDENT: Please read and complete all of the following categories – **do not leave any blank spaces** (you may write "None" where appropriate). *You have already been accepted* as meeting the academic and other requirements for Le Moyne College's Travel Abroad Program. The information you submit will be reviewed by the travel abroad program director and health services, and recommendations and/or determinations may be made about your participation in Program activities. In addition, the information may be used as an aid to providing necessary health care.

NOTIFY THE TRAVEL ABROAD PROGRAM DIRECTOR IF YOU ARE EXPOSED TO ANY COMMUNICABLE DISEASES (E.G., CHICKEN POX, HEPATITIS, ETC.) AND/OR HAVE ANY ILLNESSES, INJURIES OR OTHER CONDITIONS AFTER COMPLETION OF THIS FORM. THIS COMPLETED FORM MUST BE ON FILE BEFORE YOU LEAVE.

By signing below, I acknowledge that I have read and understand this document and further agree as follows: I give permission for Le Moyne College, its representatives or overseas partners to notify my emergency contact(s) or previous medical providers in the event of an emergency abroad. In the event that I need medical care, hospitalization, treatment, medications, or surgery while participating in the program, I understand that every effort will be made to reach my emergency contact(s). In the case that my emergency contact(s) cannot be reached and I am unable to consent for myself, I hereby grant permission to any provider called by Le Moyne College faculty/staff or site personnel to render medical, dental, and hospital services to me, when, in that provider's judgment, an emergency exists such that delaying treatment would risk life or health. I agree that any treatment would be at my own expense.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Person to notify in case of emergency, illness or accident:

Name: _____ Relationship to student: _____
Address: _____ Daytime phone #: _____
City, State, ZIP: _____ Evening phone #: _____
Email address: _____ cell phone #: _____

Second person in the event that the above person cannot be reached:

Name: _____ Relationship to student: _____
Address: _____ Daytime phone #: _____
City, State, ZIP: _____ Evening phone #: _____
Email address: _____ cell phone #: _____

Medical History
Please circle all that apply

Medications

_____

_____

_____

Allergies

Meds:

_____

Foods:

_____

Other:

_____

Surgical History/Hospitalizations

_____

_____

_____

Infectious Disease
Infectious mononucleosis
Rheumatic Fever
Tuberculosis
Malaria

Eyes, Ears, Nose, Throat
Wears glasses/contacts
Other visual problems
Hearing loss/deafness
Recurrent sinus infections
Recurrent ear infections
Recurrent nose bleeds

Cardiopulmonary
Chest pain w/exercise or exertion
Shortness of breath w/excessive
Unexplained fatigue w/exercise
Heart murmur
Mitral valve prolapse
Elevated blood pressure
Rheumatic heart disease
Heart palpitations/irregular beats
Congenital heart defect
Asthma
Bronchitis/pneumonia
Cardiovascular disease

GI
Reflux/GERD
Ulcer
Pancreatitis
Gall bladder disease
Hepatitis: type_____
Hernia
Rectal bleeding
Irritable bowel
Crohn's disease
Ulcerative colitis

GU
Cystic/bladder infection
Blood in urine
Kidney infection
Kidney disease
Sexually transmitted disease

Female
Pelvic/vaginal infections
Currently pregnant
Painful periods
Irregular periods
Heavy flow

Males
Testicular lump
Testicular torsion
Undescended/absent testicle
Hydrocele/varicocele

Musculoskeletal
Arthritis
Bone/joint problems
Scoliosis
Back pain/problems
Other:

_____

Hematologic/oncologic
Anemia
Sickle cell trait/disease
Leukemia/lymphoma
Hemophilia
Immune deficiency
Cancer
Neurologic
ADD/ADHD
Seizure disorder
Migraine headache
Tension headache
Concussion
Head injury w/loss of consciousness

Skin
Hives
Chronic rash
Tattoos/piercings
Other: _____

Metabolic
Diabetes
Thyroid disorder
Other endocrine dx: _____

Mental/Emotional
Anger management
Eating disorder
Drug/Alcohol dependency/abuse
Depression
Panic/anxiety disorder
Obsessive compulsive disorder
Schizophrenia
Deliberate self-harm
Previous psychiatric hospitalization
Other: _____

Other Medical History

_____

_____

Dietary Restrictions

_____

********* The student is responsible for bringing all required over the counter and prescription medications for the entire duration of the trip.**

The medical and psychological information provided above is complete and true to the best of my knowledge. I recognize that falsification or omission of information may jeopardize my own health and safety as well as that of other travel abroad participants and could be grounds for non-participation.

In addition, I have made arrangements to have all the vaccinations that are required by the program and the Centers for Disease Control (CDC) and I have reviewed the recommendations from the CDC.

Student signature: _____ Date: _____

Medical Approval

MEDICAL APPROVAL TO BE SIGNED BY YOUR PERSONAL PHYSICIAN, an URGENT CARE PROVIDER or THE LE MOYNE HEALTH CENTER (PHYSICIAN, PHYSICIAN ASSISTANT, OR NURSE PRACTITIONER).

This student is participating in a Travel Abroad Program that may include living and functioning in unfamiliar environments, long periods of outdoor activity in cold or hot weather conditions, intense emotional experiences, and/or strenuous physical activity (e.g., walking several miles a day, hiking in rough terrain, carrying equipment or supplies, repairing houses, maintaining grounds).

I have reviewed this student's available medical and vaccination records and I believe that his/her physical and mental health will permit him/her to participate in:

_____ unlimited activity during the Travel Abroad Program.

_____ limited activity during the Travel Abroad Program as described here:

_____

_____

Additional Comments/Recommendations: _____

_____

Medical Provider's Signature _____ Date _____

Medical Provider's Name (print) _____

Provider's Address _____

_____