Medical History Form

Name: ____ **Program:** _________________________
(Please print)

1. Blood type (if known) _________

2. What illnesses, conditions or injuries have you received medical treatment for in the past five years?

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3. Are you currently under treatment for any physical or emotional condition? Please explain.

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4. List any ongoing physical or emotional conditions which might require immediate treatment abroad due to changes in climate, diet, exercise, etc. What treatment is recommended?

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5. Are you currently taking any medication(s) on a regular basis? If so, please name and describe the purpose of the medications prescribed.

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6. List any medications to which you are allergic.

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7. Do you have any other allergies (foods, plants, animals, bee stings…)?

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8. Do you wear contact lenses? ___________

9. Do you have any condition which might prevent you from climbing steps or participating in excursions? If so, please describe.

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    ____

10. Do you have dietary restrictions? If so, list those restrictions.

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11. Provide contact information for your primary physician.

    Name: ____

    Address: ____

    Office Phone: _____________________ Fax: _________________

Failure to disclose any medical condition may result in removal from the program. A doctor's letter releasing you to participate may be required.

Signature: ____ Date: __________________