

IES MEDICAL REPORT

PART I: STUDENT SELF EVALUATION

Name _____ Program Location _____ Program Dates _____
Home College _____ Email Address _____
Home Phone _____ School Phone _____ Cellular Phone _____

To be completed by the student: Please complete and sign PART I of this form. You are responsible for coordinating with a physician, certified nurse practitioner or physician's assistant to complete PART II of this form after having a CURRENT exam. Please return the ORIGINAL form to to your school representative by the specified due date. No copies or other medical forms will be accepted in substitution.

YOUR PHYSICAL EXAMINATION MUST TAKE PLACE WITHIN SIX MONTHS OF YOUR PROGRAM START DATE.

Gender M _____ F _____ Date of Birth _____
Do you hold religious beliefs that might impact the provision of emergency medical treatment while you are abroad? YES _____ NO _____
If yes, give details. _____
Are you required to or do you wear a health emergency bracelet? YES _____ NO _____ If yes, for what condition? _____

Have you had or do you currently have any of the following conditions? Please mark all that apply, **specifying the date**, whether past or current. If yes, please detail information. Attach additional sheets if necessary.

MEDICAL CONDITION	PAST DATE	CURRENT	IF YES, PLEASE DETAIL INFORMATION.
1. Alcohol/Drug addiction	_____	_____	_____
2. Allergies	_____	_____	_____
3. Asthma	_____	_____	_____
4. Cancer	_____	_____	_____
5. Chronic Condition	_____	_____	_____
6. Diabetes	_____	_____	_____
7. Eating Disorder	_____	_____	_____
8. Epilepsy/Seizure Disorder	_____	_____	_____
9. Frequent Trouble Sleeping	_____	_____	_____
10. Heart Disease	_____	_____	_____
11. Hypoglycemia	_____	_____	_____
12. Painful shoulder, knee or back	_____	_____	_____
13. Thyroid Condition	_____	_____	_____
14. Chronic Headaches/Migraines	_____	_____	_____
15. Other:	_____	_____	_____

If you have ever been hospitalized or been treated in an emergency room, you must provide treatment details here (please attach an additional sheet if necessary):

Date(s)	Reason for/Nature of Treatment	Outcome/Present Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently taking any medications? YES _____ NO _____ If yes, which medications and for what? _____

Have you ever been treated for any psychological/emotional problems? YES _____ NO _____ If yes, list dates: _____

If yes, please describe the nature of the problem: _____

Did or does your treatment require medication? YES _____ NO _____ If yes, please list medications: _____

Current Status: _____

PLEASE NOTE: The following questions address disability-related needs of students. Provision of the following information is voluntary.

Do you have a documented disability as defined by the Americans with Disabilities Act? YES _____ NO _____

If yes, please state the nature of the disability _____

In which areas does your disability currently impair your ability to perform daily academic activities? _____

Are you requesting any accommodations from IES for the above listed disability? _____ YES _____ NO

If yes, separately please provide documentation from a qualified professional that speaks to your current needs for accommodation. For full consideration, this information must arrive at IES Chicago at least 4 weeks prior to the program start date.

In signing this document, I verify that all of the medical and psychological information I have provided is accurate and complete. I understand that the alteration and/or omission of any aspects of my medical and psychological history could be considered violations of the IES Code of Student Conduct which, in turn, could result in my dismissal from the program. I agree I will notify IES immediately of any relevant changes in my health that occur prior to the start of the program.

SIGN HERE Student Signature _____ Date _____

Student is responsible for completing Part I and coordinating with the physician to complete Part II after exam. Both sides of the form must be completed before submission. Incomplete forms will be returned to the student. Student must return ORIGINAL form (faxes not accepted) by the deadline to their school representative.

[PLEASE TURN OVER FOR PART II: PHYSICIAN EXAM]



EXAMINATION DETAILS

The physician MUST complete ALL items in this box for this form to be accepted as complete.

Patient's Name _____ Examination Date: _____
Blood Pressure _____ Height _____ Weight _____
How long have you known the patient? _____

MEDICAL HISTORY/CURRENT CONDITION(S)

The physician should check all that apply and provide details, if applicable, where requested.

- | | | |
|--|---|---|
| <input type="checkbox"/> Allergies of any kind | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Neurological condition |
| <input type="checkbox"/> Anaphylactic Shock | <input type="checkbox"/> Frequent indigestion or ulcer | <input type="checkbox"/> Reaction to antibiotics |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart or circulatory complications | <input type="checkbox"/> Recent gain of weight |
| <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Head injury | <input type="checkbox"/> Recent loss of weight |
| <input type="checkbox"/> Chronic respiratory problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Chronic digestive/g.i. problems | <input type="checkbox"/> Jaundice/hepatitis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Liver or gall bladder problems | <input type="checkbox"/> Trouble with eyes, ears, nose, or throat |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dizziness/fainting spells | <input type="checkbox"/> Narcotic/alcohol dependency | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Psychological/emotional/psychiatric conditions | <input type="checkbox"/> Other: _____ |

If the patient has ever been hospitalized or been treated in an emergency room, please provide treatment details here:

Date(s)	Reason for/Nature of Treatment	Outcome/Present Condition
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach an additional sheet if necessary.

MEDICATION(S)

If the patient is now taking any medication that he/she will be bringing with him/her on the IES study abroad program, please provide details of all medication. Additionally, please discuss with patient means to obtain necessary supply of medicine while abroad.

Name of Medication	Prescribed for	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach an additional sheet if necessary.

SUMMARY & SIGNATURE

Is there any medical condition that currently affects this patient and may require follow-up care while the patient is abroad?

- YES : Please explain
 NO

Is there any psychological condition that is currently affecting this patient?

- YES : Please explain
 NO

With my signature below, I acknowledge the patient is physically and mentally able to participate in a study abroad program.

SIGN HERE 

Examiner's Signature _____ Date _____

Examiner's Name (please print) _____ Title _____

Examiner's Address _____

Examiner's Telephone Number _____

Student must return the ORIGINAL, completed form (faxes not accepted) by the specified due date.