SMITH COLLEGE

Smith College Global Programs Abroad

Medical Review Forms

Smith College is committed to working with students to promote and support their health and wellbeing while abroad. Prior to departure, students must submit this Medical Review Form. Since studying abroad often involves higher stress levels that may exacerbate existing physical or emotional conditions, students are strongly encouraged to fully disclose their medical history. In doing so, the information provided will help the Smith College Deans for International Study and Program Directors ensure that students' needs are met. It is also critical that this information is available in case of an emergency. We ask that you sign a release permitting us to communicate the information to medical providers and emergency contacts. At the completion of the program, all student medical information will be destroyed.

Accommodations

University and living facilities abroad may not meet U.S. standards of accessibility for persons with physical or learning disabilities; similarly, dietary needs and restrictions may not be able to be met. If students require special accommodations because of a disability, please notify the Smith College Office for International Study (OIS) in writing as soon as possible. A letter from the Office for Disability Services documenting and confirming the request for accommodations will also need to be provided.

Instructions

This medical review should be submitted to the Smith College Office for International Study, Wright Hall, Northampton, MA 01063.

Part I –**Medical Report** to be completed by student. Keep a copy of this form for your records and to submit to the doctor you ask to complete Part II. Part I should be submitted with your enrollment confirmation materials within three weeks of the offer of admission.

Part II -- Medical Report to be completed and signed by a physician or medical professional, nurse practitioner or physician's assistant. The information **must be based upon a physical examination conducted within the past 6 months**. Reports completed by a relative are not acceptable. If Part II cannot be completed before the enrollment confirmation deadline, include a note with an appointment date. Students need to be sure to sign the waiver at the top of the form.

Part II Due Dates:

For Smith Programs Abroad (Florence, Geneva, Hamburg, Paris): Part II must be submitted by no later than June 1 for programs with a fall start or **October 1** for programs with a spring start.
For Global FLEX Programs: Part II must be submitted **at least 45 days before** the program's departure.

Change of Status: Students are responsible for notifying Smith College Office for International Study of any changes in their medical history prior to their departure and while on the program.

Smith College Global Programs Abroad
Part I: Medical Record - To be completed by student

This information will be kept on file during your enrollment on the program for use in an emergency; full disclosure is encouraged.

Name: _____ Birth date: _____
Last, First, Middle month/day/year

Pronouns: _____ Sex assigned at birth: _____ Gender identity: _____

Program: _____ Term: _____

Home Mailing Address _____

_____ City,
State, Postal Code, Country

Current Telephone _____ College Affiliation (if other than Smith): _____

PERSONAL HISTORY – Please check if you have had:

- ❒ Anxiety
- ❒ Asthma
- ❒ Cardiac history
- ❒ Depression
- ❒ Diabetes
- ❒ Eating Disorder
- ❒ Renal Disorder
- ❒ Seizure Disorder
- ❒ Thyroid Disorder

SURGICAL HISTORY:

- ❒ Appendectomy
- ❒ Tonsillectomy
- ❒ Other: _____
  _____

In the past six months, have you had:

- ❒ Back problems
- ❒ Blood in urine
- ❒ Cancer or leukemia
- ❒ Chest pain/pressure
- ❒ Chronic cough
- ❒ Chronic diarrhea
- ❒ Chronic rash
- ❒ Eczema
- ❒ Eye problems
- ❒ Gallbladder disorder
- ❒ Gastrointestinal disorder
- ❒ Hearing loss
- ❒ Heart murmur
- ❒ Heart palpitations
- ❒ Hernia
- ❒ Immune system problems
- ❒ Irregular periods
- ❒ Kidney stones
- ❒ Musculoskeletal injury/disorder
- ❒ Painful/swollen joints
- ❒ Recent weight loss or gain
- ❒ Recurrent dizziness
- ❒ Severe cramps
- ❒ Severe headaches
- ❒ Shortness of breath, wheezing
- ❒ Sinus problems
- ❒ Unexplained Fever

Comment on any conditions above that you have checked. _____

_____

ALLERGIES:

Seasonal/Environmental (please specify): _____
Foods (please specify): _____
Immunizations (please specify): _____
Prescription or over the counter medications: (Please specify. Note Reaction): _____
_____
_
Other (please specify): _____

HABITS: (specify how much/how often):

Alcohol: _____
Marijuana (smoking/edibles): _____
Tobacco/vaping: _____
Other substances: _____

FAMILY HISTORY: Age State of Health

Father:	_____	_____
Mother:	_____	_____
Brothers:	_____	_____
Sisters:	_____	_____

Smith College Office for International Study
Wright Hall, Northampton MA 01063
Phone 413-585-4905 Fax 413-585-4982

Smith College Global Programs Abroad
Part I: Medical Record – To be completed by student

Name: _____ Birth date: _____

REVIEW OF PAST ILLNESSES AND SYMPTOMS:

Please answer all questions. Use extra paper to provide details if needed. **DO NOT LEAVE ANY QUESTION BLANK.**

1. Has your physical activity been restricted during the past three years? Give reasons and duration.
   _____
2. Have you been hospitalized? If yes, give diagnosis and date.
   _____
3. Have you ever had a serious acute illness in the past three years? If yes, give details.
   _____ _____
4. Do you have any chronic/recurrent illness? If yes, give details.
   _____
5. Do you take any prescription medications, including oral contraceptives, immunotherapy, antidepressants, and psychiatric medications? If yes, give details.
   _____
6. Are you currently receiving injections or prescription medication for an allergy? If yes, give details.
   _____
7. Do you have any habits that might adversely affect your health? Explain.
   _____
8. In the last three years, have you received treatment for any mental health disorder/condition? Please provide information about the treatment plan and any continued recommendations.
   _____ _____
9. Do you have any dietary restrictions or preferences? If yes, give details.
   _____

Emergency Contact Information:

Person to contact in an emergency: _____ Phone: _____

E-mail: _____ Relationship to student: _____

Authorization to Release Medical Records and Permission for Emergency Medical Treatment

As a participant in a Smith College program, trip or activity abroad, I hereby authorize the physicians and medical providers completing Parts II and III of this medical form, to release any and all medical records and information pertaining to me to Smith College. I also authorize the release by Smith College of my medical records and information to my parent or other designated contact person in the event of an emergency.

On rare occasions, an emergency requiring treatment in a hospital and/or surgery may develop. In most cases, administration of an anesthetic, treatment of an injury, or operation upon an individual cannot be done without consent of the patient. In order to prevent a dangerous delay in an emergency situation where Smith College is either unable to contact my parent or guardian, or if I am unconscious or otherwise unable to give you my consent, I hereby authorize Smith College's representative to secure whatever medical treatment is deemed necessary, including administration of an anesthetic and surgery.

I hereby verify that all of the information contained in this form is accurate and complete, and acknowledge that any failure to provide accurate and complete information, including notification to Smith College of changes in my health affecting the accuracy or completeness of the information contained in this form, may result in my dismissal from the program. I agree to notify the Smith College office supporting my program of any material changes in my health that occur prior to the start of the program or while on the program.

Signature of Student _____ Date_____

Name: _____ Birth date: _____

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Wright Hall, Northampton MA 01063
Phone 413-585-4905 Fax 413-585-4982

Smith College Global Programs Abroad

Part II: Medical Report – To be completed by physician or provider

For the student:

Name of Student: _____ Program location and duration _____

As a participant in a Smith College Program Abroad, I hereby authorize the physicians and medical providers completing Part II this medical form to release any and all medical records and information pertaining to me to Smith College.

Signature of Student _____ Date _____

To the examining physician or provider:

Study abroad can be physically and, particularly, mentally challenging. Mild or pre-existing health conditions can become serious for some students as they transition into an unfamiliar culture and environment. Some medications may also be difficult to obtain should they be lost or needed in an emergency. In order to ensure this student's wellbeing, please review this student's health history. We request full disclosure of any health history that could potentially be problematic for this student, and that you provide additional information that could be useful in the event of treatment by a doctor or medical facility abroad.

1. Blood Pressure _____ Pulse: _____ Height: _____ Weight: _____ BMI: _____

2. Are there any abnormalities in the following systems? **If none**, check here**. _____**

Yes	No		Yes	No	
___	___	Head, eyes, ears, nose or throat	___	___	Gastrointestinal
___	___	Teeth, gums	___	___	Hernia
___	___	Skin	___	___	Metabolic/Endocrine
___	___	Immune system, including lymph nodes	___	___	Musculoskeletal
___	___	Cardiovascular	___	___	Neurologic
___	___	Respiratory	___	___	Mental Status

3. Is this student currently under medical treatment or taking medication? Please list medications and treatment plan.

_____

_____

_____

4. Does this student have any allergies (including allergies to medication and/or food)? If yes, is there a history of asthma, anaphylaxis, and other dangerous allergic conditions? _____

_____

_____

5. Recommendation for physical activity: Unlimited _____ Limited _____ (If limited, please explain.)

_____

_____

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Name: _____ Birth date: _____

Smith College Global Programs Abroad
Part II: Medical Report - To be completed by physician or provider

6. Does this student have any physical, mental or emotional conditions that might affect her participation in this program? If so, please indicate the nature of the conditional and treatment required while this student is abroad.

_____

_____

_____

_____

Medical Professional's Clearance

Based on the student's medical history and physical exam today, I consider _____

to be an appropriate candidate for participation in a Smith study abroad program in

_____ during the _____,

location of program term term and year

with the following stipulations:

- ❒ None
- ❒ Needs access to: *(i.e. counseling, exercise, etc…)* _____
- ❒ Receives clearance by a specialist in the field of _____

  (Form "Statement of Ability to Travel" must be completed by the specialist and returned to the **Smith College Office for International Study - see below**)

Other: _____

Signature of medical professional (MD/DO/NP/PA) _____ Date: _____

Printed name: _____ Title: _____

Mailing address _____

_____

Telephone: _____ Fax: _____

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SMITH COLLEGE

Smith College Global Programs Abroad
Letter to Specialist/Other Provider "Statement of Ability to Travel"

Name of Student_____ Birth Date: _____

Dear _____,

The above-named patient has identified you as a caregiver.

This patient is traveling to _____ from _____ to _____ dates. The itinerary may include travel to remote areas where there is little to no access to medical and other healthcare services; altitude; risk of food-water borne illnesses, and other challenges.

Please advise regarding this patient's risk and ability to travel safely with or without restriction, and provide an explanation of any restrictions and accommodations that may be indicated in the space provided below.

In my professional opinion, this student may:

- ❑ **Travel safely without restriction or accommodation.**
- ❑ **Travel with the following restrictions and/or accommodations, as indicated below.**
- ❑ **This student is unable to travel safely, for the reason(s) indicated below.**

Comments/Restrictions/Accommodations:

_____

_____

_____

_____

_____

Respectfully yours,

Signature _____ Date _____

Printed name_____

Specialty _____

Address _____

PLEASE RETURN THIS STATEMENT OF ABILITY TO TRAVEL TO:

Smith College Office for International Study
Wright Hall, Northampton MA 01063
Phone 413-585-4905 Fax 413-585-4982