Report of Medical History & Emergency Contact

ACM ASSOCIATED COLLEGES OF THE MIDWEST

Student: Please read, complete, and sign this form. Ask your college nurse or family physician to **complete Part 3**. Your nurse or physician should have given you a physical exam within the past three years. Return the completed form to the ACM office.

Name

Program and Year

Date of Birth

College

Cell phone

Please list two people ACM may contact on your behalf in case of an emergency while the program is in session:

Person to Notify in Case of Emergency

Emergency Contact Phone Number

Relationship to Student

Emergency Contact Email

Person to Notify in Case of Emergency

Emergency Contact Phone Number

Relationship to Student

Emergency Contact Email

Part 1 – To Be Completed By Student

HEALTH AGREEMENT UPDATE
I understand if there are any changes to my health status before and during my off-campus study it is my responsibility to immediately notify the Program Director.

INSURANCE INFORMATION
ACM will provide program participants with international medical insurance. Students will receive an insurance card and are required to carry that card throughout the program. ACM recommends that students maintain any domestic health insurance that they have during the program in order to cover additional expenses not covered by the international policy. I understand that I am financially responsible for all personal medical expenses. ACM does not provide personal property insurance. I understand that I should check with my insurance provider to ensure coverage of my personal property.

MEDICAL RELEASE OF INFORMATION
I understand that my express consent is required to release any health care information. I authorize release of my medical history as reported on the following pages to the Program Director and appropriate staff at the site of my program. In addition, in a case of emergency, I authorize release of my medical history to a health care provider at the site of my program.

TRAVEL IMMUNIZATION INFORMATION
I am aware that certain locations require additional immunizations and health precautions. It is my responsibility to consult with my doctor and review the recommendations on the Center for Disease Control website, www.cdc.gov/travel, for up-to-date information regarding immunizations and health precautions. In addition, it is my responsibility – if I am traveling to a place requiring immunizations or medications – to schedule an appointment to receive travel-related health information, immunizations and/or medications.

By my initials below, I certify that I have read and understand the above:

_____ HEALTH AGREEMENT UPDATE

_____ INSURANCE INFORMATION

_____ MEDICAL/MENTAL HEALTH RELEASE OF INFORMATION

_____ TRAVEL IMMUNIZATION INFORMATION

FURTHERMORE, I CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND COMPLETE.

_____ _____

Student Signature Date

Part 2 – To Be Completed By Student

In the space provided, please explain all answers in full (dates, locations, diagnosis)
The information requested will allow ACM to make arrangements to accommodate, to the extent possible, any special needs (e.g., food, housing) and to better assist you should health concerns arise during your off-campus study experience, and particularly in the event of a health emergency. The information provided will be shared with on-site program staff.

1) Do you have any allergies (medicines, dietary, etc.)? If yes, please list.

2) Have you been treated by clinics, physicians, or other health practitioners in the last five years for other than routine check-ups? If yes, please explain.

3) Have you been diagnosed or treated for an eating disorder (anorexia, bulimia nervosa, etc.)? If yes, please explain.

4) Do you have any dietary restrictions? If yes, please explain.

5) Do you take prescription and/or over-the-counter medication routinely? If yes, please give type and reason.

6) Have you been treated for chemical dependency? If yes please explain, type and duration of program.

7) Are there any mental or emotional issues ACM should be aware of? If yes, please explain.

8) Will you require special accommodations or support services while off-campus because of a disability (learning, visual, hearing, mobility, psychiatric) or other impairment? If so, please provide us with details.

Personal History
Please check if you have had any of the following:

____ Anemia	____ Head Injury with unconsciousness	____ Mumps
____ Arthritis	____ Heart Murmur	____ Recent weight gain/loss
____ Asthma	____ Hemophilia	____ Rheumatic fever
____ Back Problems	____ Hernia	____ Seizures
____ Chicken Pox	____ High or low blood pressure	____ Severe menstrual cramps
____ Convulsions	____ Irregular periods	____ Sexually transmitted disease
____ Diabetes	____ Kidney disease/injury	____ Stomach problems
____ Dizziness or fainting	____ Malaria	____ Tuberculosis
____ Ear, nose, throat trouble	____ Measles	____ Tumor, cyst, or cancer
____ Eye problems	____ Mononucleosis	

Details about any checks above:

Immunization Dates
Note: these are not necessarily required immunizations; please consult your doctor for immunization advice.

TB Test _____ _____ positive _____negative

Measles _____ _____ Mumps _____ _____ Rubella _____ _____

Tetanus _____ _____ Diphtheria _____ _____ Polio _____ _____

Hepatitis A _____ _____ Hepatitis B _____ _____ _____ Yellow Fever _____

Any additional vaccinations

I certify the above information is true and correct to the best of my knowledge, and I will notify ACM of any relevant changes in my health that occur prior to the start of the program. I understand that failure to supply true and accurate information may result in my dismissal from the program.

_____ _____

Student Signature Date

Part 3 – To be completed by student's physician

Please review the student's personal history on the previous two pages and complete the following section. Please comment on all answers. This information will be used as background for providing health care in emergency situations. Because mild, pre-existing health conditions can become serious under stresses of life while studying off-campus, it is important that a healthcare provider evaluate any condition which might limit the participant's ability to successfully undertake an off-campus study program. ACM will make every effort to accommodate health needs abroad and to ensure that suitable care is available.

Student Name _____ Program _____

1) Is the information provided by the student in Part 2 of this record complete and correct to the best of your knowledge? If not, please clarify.

2) Does this student have any physical condition, disability or impairment which might inhibit full participation during a period of strenuous activities or an extended stay off-campus or in the field?

3) Please note any other information, including details of current treatment, which would be helpful to a physician treating or faculty working with this student on the program.

To the best of my knowledge, the applicant is in good physical and mental health, and should be able to complete a full program of off-campus study.

Physician's Signature _____ Date _____

Physician's Name _____ Specialty _____

Street Address _____ Phone Number _____

City, State, Zip _____