Part VIII - MEDICAL REPORT

It is **imperative** that you fill out all pages of this form honestly and accurately. Our intention is to learn as much as possible about your physical, emotional and psychological needs so that you can have a successful international/off-campus experience. It will assist us in obtaining or providing appropriate care if there is an emergency.

This medical report is subject to review by the Medical Director on your campus (for Non-SLU students), the St. Lawrence University Health Center staff (for all students), the program director and administrators at the Center for International and Intercultural Studies. The selection committees do not see this material and you will not be rejected on the basis of either a physical or emotional condition unless:

- it is of such a serious nature or degree as to prevent successful participation in the program;
- medical care for an individual's medical problem is not available in the program area;
- and/or the living and environmental conditions to which the applicant could be exposed would present a serious risk to his/her health and/or the health and safety of others.

Should you develop any significant health problems between the time of acceptance into the program and commencement of the off-campus component, **it is your responsibility** to notify the program director. A **medical report** should accompany this notification for review by the Director of Health Services.

FOR NON-SLU STUDENTS:

Make arrangements for a copy of your Pre-Admission Health Record, including immunization records, to be sent to:

Outdoor Studies
St. Lawrence University
Canton, NY 13617
FAX: (315) 229-5019

I. GENERAL INFORMATION

Program: ______________________________

Name: ____ Sex: ____ Birth Date: _____/_____/_____

Name of university/college: _______________________________

Campus Address: ____ Phone: _______________

Parent/Guardian Name(s): ____ Phone: _______________

Address: ____
(street address) (city) (state) (zip)

II. CURRENT IMMUNIZATIONS **If you have received the immunizations listed below since you enrolled in college, please list them here.**

Date of last tetanus (Td) shot ___________

Hepatitis A ___________ ___________ (dates)
and
Hepatitis B ___________ ___________ ___________ (dates)

OR

Twinrix A/B (Hepatitis A and B combined) __________ ___________ ___________ (dates)

III. CURRENT HEALTH QUESTIONNAIRE

1. Your height in inches: ________ Your weight in pounds: ________

2. Please list all medications – and dosage – you are currently taking, including over-the-counter medications.

____

____

____

3. Have you ever had an allergic reaction to anything? Yes ___ No ___

If yes, please list (be specific): ____

How sever is your reaction (symptoms)?:____

4. Do you have any physical handicap or disability? Do you have any orthopedic problems that restrict physical activity?
Yes ___ No ___

If yes, please describe: ____

____

5. How much alcohol do you normally drink in a week? ____________________________

6. Have you been placed on social or disciplinary probation for an incident in which alcohol or drugs were involved?

Yes ___ No ___

If yes, please explain: ____

____

7. Have you been hospitalized during the past year? Yes ___ No ___

If yes, please explain: ____

____

8. Are you currently, or have you recently been, involved in friend/family relationships that have caused you unusual stress?

Yes ___ No ___

If yes, please explain: ____

____

9. Do you have any dietary restrictions? Yes ___ No ___

If yes, please list: ____

____

10. Have you any significant chronic medical conditions requiring on-going medical supervision and treatment, or have you had in the past any significant chronic medical conditions which are currently in remission? (for example: diabetes mellitus, heart problems, chronic or recurrent gastrointestinal disorders, seizure disorders treatment for cancer, bleeding disorders, etc.)

*Yes ___ No ___

If yes, please list: ____

11. Are you currently receiving, or have you received in the past two years, counseling in the treatment of any emotional problem, drug addiction, alcohol problem, psychiatric condition, or eating disorder?

*Yes ___ No ___

* If you answered "yes" to #10 or #11, the physician/counselor primarily responsible for your care must complete Section V.

12. Is there any other information that would be helpful to the program director or on-site medical staff? ________

____

______________________________ Please contact the Winning Health Center staff if you have any questions.

The responses I have given are correct and complete to the best of my knowledge.

______________________________ ______________________________

Signature of Applicant Date

RETURN COMPLETED FORM TO: OUTDOOR STUDIES
ST. LAWRENCE UNIVERSITY
CANTON, NY 13617

IV. MEDICAL RELEASE

All students must complete this side of the form.

A visit to your physician is not required unless your doctor considers it necessary to update the evaluation of your medical condition. **ONLY STUDENTS WHO ANSWERED "YES" TO SECTION III, ITEM(S) 10 AND/OR 11, MUST HAVE THE PHYSICAN/COUNSELOR PRIMARILY RESPONSIBLE FOR TREATMENT COMPLETE SECTION V ON THE REVERSE SIDE OF THIS FORM.**

Student Name ____

Program ____

Condition(s) listed in Section III, # 10 and/or # 11

____

____

____

____

I am requesting copies of the following from my medical/psychiatric record be released to the Outdoor Studies Program. I understand these records will be reviewed by the Medical Director on my campus (for Non-SLU students), the St. Lawrence University Health Center staff (for all students), the program director, and members of the Adirondack Semester Selection Committee..

❐ Immunization record ❐ Medical visits ❐ Other (please describe) __________

____

Signature _______________________________ Date _______________

Phone number ___________________________

Please forward records to:

Outdoor Studies
St. Lawrence University
Canton, NY 13617
Fax: (315) 229-5019
Phone: (315) 229-5016

Applicant's Name ______________________________________ Program ____________________________

TO BE COMPLETED BY PHYSICIAN/COUNSELOR PROVIDING TREATMENT IF APPLICANT ANSWERED "YES" TO PART III, ITEM(S) 10 AND/OR 11

V. PHYSICIAN/COUNSELOR REPORT

The applicant has indicated an on-going health problem. You are being asked to evaluate the physical and mental health of the above named applicant for selection into an off-campus program. Living in unfamiliar surroundings and adjusting to cultural differences can create emotional and physical stresses that can exacerbate mild disorders.

Individuals in this program will at times be in remote areas exposed to harsh environmental conditions with poor water supply and away from immediate, full-service medical care. Gastrointestinal problems are common. Individuals with certain medical conditions which can lead to electrolyte imbalance such as inflammatory bowel disease, diabetes mellitus and insipidis, as well as individuals on psychopharmacological medications, would be at greater risk, as would persons with unstable seizure disorders, problem asthmatic patients, and individuals with cardiac disorders. Supervision of psychiatric conditions is not practical.

If additional space is required, please attach report.

Diagnosis:

Medications and dosages:

Diet:

Stability of condition over past two years:

Recommendations for the care of this individual:

Is this individual capable of participating in the program? Yes ______ No ______

Please contact the Winning Health Center with any questions or concerns: 315-229-5392

Signature of physician/counselor: ____ Date: ____/____/____

Name of physician/counselor (printed):____

Address: ____
(street address) (city) (state) (zip)

Telephone: __________________________________ Fax: ________________________________