Middlebury Schools Abroad
Post-Acceptance Health Information Form and Release

Name ___________________________ School Abroad _________________ Date of Birth ________________
(day/mo/yr)

The purpose of this form is to help Middlebury College be of assistance to you should the need arise during your study abroad experience. Mild physical or psychological conditions can become more serious under the stresses of life while studying abroad. Moreover, the system of US health care is unlikely to be replicated in the host country. It is therefore *extremely* important that we be made aware of any medical or psychological/psychiatric conditions, previous or current, that you may (have) suffer(ed) from so that the director abroad will be better able to respond appropriately should any such condition become exacerbated in a foreign study context.

Please answer the following questions as honestly and completely as possible. You should consult with your treating physician(s) regarding what information should be provided. The information will only be used in circumstances where it is judged by the program director to be essential to your well-being.

(1) Please describe any chronic conditions (such as asthma, diabetes, epilepsy, depression, bi-polar disorder etc.) that you may suffer from, even if currently controlled by medication:

(2) Please give details of any hospitalizations within the past three years:

(3) If you are currently receiving, or have received in the past three years, counseling for the treatment of any emotional problem, drug addiction, alcoholism, psychiatric condition, or eating disorder, please describe.

(4) Please describe any other physical or mental health conditions or concerns you may have.

(5) Please list any prescription medications you are currently taking: (Be sure to take a sufficient supply of critical, prescription medications to last for the duration of your stay abroad.)

(6) Please list all allergies (including to specific medications):

In case of emergency, please notify:

Name ______________________________________ Name ______________________________________
Relationship ______________________________ Relationship ______________________________
Street ____________________________________ Street ____________________________________
City _____________ State ____ Zip _____________ City _____________ State ___ Zip __________
Tel (home) ___________ Tel (work) _______________ Tel (home) ___________ Tel (work) __________

I hereby verify that all of the information contained in this form is accurate. I agree to notify Middlebury College of any significant changes in my physical/mental health that occur after submitting this form. I authorize Middlebury College to send one copy of this form to the Director of the School Abroad and to keep one copy in my file at Middlebury. I understand that information contained herein will remain confidential unless judged by the Director of the School Abroad to be essential to my well-being. I authorize the release of this information to health care providers abroad in emergency situations, at the discretion of the Director of the School Abroad. I also grant permission to my primary care physician to release my medical history and immunization records upon the request of the Director of the School Abroad should receipt of such information be judged by the Director to be essential to my well-being.

Date ______________________ Signature ____________________________________

Please list contact information for your primary health care provider, relevant specialist(s), and the Health Services Office at your home institution. This information will only be used in an emergency.

Primary Health Care Provider:

Name ____________________________________
Street ___________________________________
City _______________________ State __________
Zip ______________ Telephone _______________

Medical Specialist (if applicable):

Name ____________________________________
Street ___________________________________
City _______________________ State __________
Zip ______________ Telephone _______________

Medical Specialist (if applicable):

Name ____________________________________
Street ___________________________________
City _______________________ State __________
Zip ______________ Telephone _______________