MEDICAL HISTORY-EMERGENCY CONTACT FORM FOR INBOUND STUDENTS

University of Maine Farmington

Student's Name: _____ DOB _____/_____/_____
mm dd yyyy

By signing this form, I consent to sharing the information contained in this Medical Information Form with the Office of Global Education and medical personnel in case of an emergency while studying at UMF.

Student Signature: _____ Date: _____

Emergency Contact (Home)

Name _____ Relationship: _____

Address _____

Telephone: _____ Email: _____

Emergency Contact (in the U.S., if applicable)

Name _____ Relationship: _____

Address _____

Telephone: _____ Email: _____

Traveling to a different culture and environment can pose emotional and physical challenges. It is important that you discuss with a medical provider any past, current or potential medical conditions to prepare you for your study program at UMF and assist you with any necessary accommodations.

The information requested in this form is necessary to identify any medical precautions that are recommended and to provide critical medical information in the event that a health problem or other emergency arises while you are studying at UMF. The information provided will remain confidential, reviewed only by the Office of Global Education and medical personnel in case of an emergency while on your program.

After you have completed this form in its entirety, you must meet with your health care provider to review your information, discuss any specific needs you may have, and obtain the requisite signature indicating that you have received this counseling and whether there are any precautions or accommodations necessary for you to participate in your study program at UMF.

PERSONAL MEDICAL HISTORY to be completed by Student (Circle all that apply).

This information will not be used to exclude a student from participation unless they cannot perform program requirements or if their participation is determined to be a direct threat to the health or safety of them or others.

Diabetes	Yes	No	Stroke	Yes	No
Heart disease or Murmur	Yes	No	Shortness of breath	Yes	No
High blood pressure	Yes	No	Other respiratory problem	Yes	No
Asthma	Yes	No	Seizure Disorder	Yes	No
Arthritis or fibromyalgia	Yes	No	Chronic Back Problems	Yes	No
Ambulatory Issues	Yes	No	Hearing Problems	Yes	No
Vision Problems (uncorrected by glasses or contacts)	Yes	No	Sinus Problems	Yes	No
Motion Sickness	Yes	No	Psychological or emotional issues	Yes	No
Phobia (Heights, Water, Flying…) specify: _____				Yes	No

If you answered **yes** to any of the above, please indicate the nature of the medical issue(s) and whether you are currently experiencing them or might expect to during your program. Add an additional page if more space is needed.

MEDICATIONS:
Are you currently taking any prescription and/or non-prescription medications? Yes No

If **yes**, please indicate so we may help to assess whether bringing them into the U.S. or obtaining them in a case of an emergency may pose a problem. Add an additional list if more space is needed.

Medication_____ Reason_____

Medication_____ Reason_____

Medication_____ Reason_____

NOTE: You must verify that all prescription and nonprescription medications are legally allowed to be imported into the United States, including transit.

ALLERGIES:
Please indicate if you are allergic to any of the following. (Circle all that apply).

Bee Stings	Yes	No	Latex	Yes	No
Nuts	Yes	No	Penicillin	Yes	No
Shellfish	Yes	No	Aspirin	Yes	No
Other Foods, Specify: _____	Yes	No	Other Medications, Specify:	Yes	Yes
Other Allergies, Specify: _____	Yes	No	_____		

If you have any allergies, please describe typical reactions and how to treat them:

_____

_____

Do you intend to **bring an epi pen or other medications** for allergies (e.g., Benadryl)? (circle) Yes No

DIETARY RESTRICTIONS:
Do you have any special dietary needs? If yes, please explain.

_____

_____

DISABILITIES OR PHYSICAL RESTRICTIONS: Please describe any disabilities or physical restrictions that could impact your ability to participate fully in any or all of the activities during your program.

_____

_____

Do you require **any accommodations** to permit you to participate fully in any activities during your program? **(circle)** Yes No

If yes, please provide details of any accommodations you would require. If you have not already discussed this with your home school study away advisor and/or the UMF Office of Global Education, you will need to do so before your program begins in order for us to connect you with the appropriate office and to ensure these accommodations can be made

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MEDICAL CARE DURING TRAVEL:

Do you anticipate needing any health care or personal counseling while at UMF? (circle) Yes No

If **yes**, please explain and provide details of what type of care you would require and how you plan to receive it during your program. This information will allow us to connect you to our health and counseling services.

OTHER MEDICAL INFORMATION: Please provide any other medical information that you think would be helpful for UMF to be aware of prior to or during your program.

MEDICAL PROVIDER'S RECOMMENDATION: After reviewing the student's medical history and current mental and physical health, please indicate any recommendations you have regarding participation in their study program in the U.S.

Medications and/or Inoculations Recommended or Required by the CDC: _____

_____

Medical or Physical Restrictions _____

_____

Medical Provider's name (please print) _____

Signature_____ Date _____

Address_____ Telephone_____

Please return completed form to:

Email: leustis@maine.edu

If you have questions about this request please contact Lynne Eustis, Assistant Director of Global Education at 207-778-7122 or leustis@maine.edu.

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