MEDICAL HISTORY-EMERGENCY CONTACT FORM FOR INBOUND STUDENTS
University of Maine Farmington

Student’s Name: ____________________________ DOB: ___/___/______

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.

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason</th>
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</table>

**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).

<table>
<thead>
<tr>
<th>Bee Stings</th>
<th>Yes</th>
<th>No</th>
<th>Latex</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuts</td>
<td></td>
<td></td>
<td>Penicillin</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Shellfish</td>
<td>Yes</td>
<td>No</td>
<td>Aspirin</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other Foods, Specify:</td>
<td>Yes</td>
<td>No</td>
<td>Other Medications, Specify:</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Allergies, Specify:</td>
<td>Yes</td>
<td>No</td>
<td></td>
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</tbody>
</table>

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.

______________________________

**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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