

MEDICAL APPROVAL FORM

(PART 1: THIS SECTION TO BE COMPLETED BY THE PARTICIPANT)

Complete Sections A-C on this form. Schedule an appointment with Creighton Student Health or your primary healthcare provider. Ask the physician to complete the reverse side. Submit the completed form to the Study Abroad Coordinator along with an immunization record from a healthcare provider (if preferred, your physician may mail or fax this form directly to the Office of International Programs).

Last Name First Name NetID

Please indicate your status at CU (faculty, staff, grad student, etc.):

SECTION A: IMMUNIZATIONS AND VACCINATIONS

List the date that you received each of the immunizations or vaccinations in the Routine Vaccination Section below. In the second column, indicate if you have discussed each vaccination or immunization with your physician, in relation to your travel destination, itinerary, and planned activities. Attach an immunization record from a healthcare provider or CU Student Health to this form.

To review recommended and required immunizations for your travel destination(s), visit The Center for Disease Control's website at: http://www.cdc.gov/travel/.

Date of most recent vaccination (mm/yyyy):

___/___/___ Hepatitis A
___/___/___ Hepatitis B
___/___/___ Influenza
___/___/___ Meningococcal Meningitis
___/___/___ MMR (measles, mumps, rubella)
___/___/___ Pertussis
___/___/___ Polio
___/___/___ Tetanus Diphtheria
___/___/___ Varicella (chicken pox)

I have discussed the following with my physician:

[] Yes [] No Dengue Fever
[] Yes [] No Hepatitis A
[] Yes [] No Japanese Encephalitis
[] Yes [] No Malaria
[] Yes [] No Meningococcal Meningitis
[] Yes [] No Rabies
[] Yes [] No Typhoid Fever
[] Yes [] No Yellow Fever
[] Yes [] No Other: _____

SECTION B: MEDICAL HISTORY & ROUTINE MEDICATIONS

Have you ever had a diagnosis in any of the following? Mark "yes or no" for each...

[] Yes [] No Cancer
[] Yes [] No Diabetes
[] Yes [] No Kidney
[] Yes [] No Thyroid
[] Yes [] No Asthma
[] Yes [] No Arthritis
[] Yes [] No Ulcer
[] Yes [] No Seizures
[] Yes [] No Heart
[] Yes [] No Alcoholism
[] Yes [] No Eating Disorders
[] Yes [] No Depression
[] Yes [] No Nervous Disorder
[] Yes [] No Other: _____

If you marked 'yes' to any of the above, please explain:

List any routine medications that you are currently taking (attach additional sheet if necessary):

SECTION C: PARTICIPANT SIGNATURE

By signing below, I authorize my healthcare provider to forward my medical information to the OIP and Creighton University. I also acknowledge that the information I have provided on the Medical Approval Form is accurate to the best of my knowledge. I agree to notify the OIP of any changes in my health that occur prior to the start of the program or while I am abroad. In the event of an emergency, I authorize the OIP to share this information with my parents/guardians, the study abroad program sponsor or host institution, and the attending physician(s) overseas, unless I notify the OIP in writing otherwise.

Participant's Signature

Today's Date

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(PART II: THIS SECTION TO BE COMPLETED BY A HEALTHCARE PROVIDER)

SECTION D: PHYSICIAN EVALUATION

Weight _____ Height _____ Temperature _____ Pulse _____ Blood Pressure _____

Urine: S.G (optional) _____ Urine: Protein (optional) _____ Lab: HGB/HCT (optional) _____ Blood Glucose (optional) _____ Other (optional) _____

Corrected RIGHT vision 20/_____ Uncorrected RIGHT vision 20/_____

Corrected LEFT vision 20/_____ Uncorrected LEFT vision 20/_____

Are there any abnormalities of the following: If yes, indicate in space below. Please indicate if not evaluated.

- | | | | | | |
|------------------------------|-----------------------------|-------------|------------------------------|-----------------------------|------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lungs/Chest | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose/Throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Abdomen |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immune System |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gastrointestinal |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Musculoskeletal |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ears | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological |

SECTION E: MEDICAL APPROVAL

Agree Disagree I have discussed with this participant, relevant vaccinations & immunizations that may be needed in relation to his/her medical needs, travel destination(s), itinerary, and planned activities.

Agree Disagree I have examined this participant, or the records of this participant, and believe that his/her health, including mental and physical, **will permit** him/her to successfully participate in a travel abroad program

If you DISAGREE with the above statement, please indicate why you feel that the participant is **NOT capable** of having a successful travel abroad experience: _____

Please indicate if, while abroad, the participant will need any accommodations or support to assist him/her with any medical conditions (physical or emotional): _____

Do you have any recommendations regarding the care of this student while he/she is abroad (emotional or physical)? _____

SECTION F: PHYSICIAN SIGNATURE AND CONTACT INFORMATION

Physician Signature: _____ Date: ____/____/____

Printed Name _____ Phone: ____-____-____

Clinic Address or Stamp: _____
Street Address City, State Zip

Submit Completed Form To:
Study Abroad Coordinator, Office of International Programs
Creighton University
2500 California Plaza
Omaha, NE 68178