Creighton UNIVERSITY

03.2008

OFFICE OF INTERNATIONAL PROGRAMS
STUDY ABROAD

PROJECT CURA
MEDICAL APPROVAL FORM
(PART 1: THIS SECTION TO BE COMPLETED BY THE STUDENT)

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 completed form to your trip leader. Attach an immunization record from a healthcare provider or CU Student Health to this form.

____ _______________

Last Name First Name NetID

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: STUDENT 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 trip leader(s) and/or the attending physician(s) overseas, unless I notify the OIP in writing otherwise.

____ _______/________/__________

Student Signature Today's Date

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STUDY ABROAD

MEDICAL APPROVAL FORM

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

SECTION D: PHYSICIAN EVALUATION

Last Name of Participant ______ First Name of Participant ______ NetID ______

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.

- ❑ Yes ❑ No Lungs/Chest
- ❑ Yes ❑ No Nose/Throat
- ❑ Yes ❑ No Heart
- ❑ Yes ❑ No Mouth
- ❑ Yes ❑ No Eyes
- ❑ Yes ❑ No Ears
- ❑ Yes ❑ No Skin
- ❑ Yes ❑ No Abdomen
- ❑ Yes ❑ No Immune System
- ❑ Yes ❑ No Gastrointestinal
- ❑ Yes ❑ No Musculoskeletal
- ❑ Yes ❑ 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 study abroad program

If you DISAGREE with the above statement, please indicate why you feel that the participant is **NOT capable** of having a successful study 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: PHYCISIAN SIGNATURE AND CONTACT INFORMATION

Physician Signature: ______ Date: ____/____/____

Printed Name______ Phone: ____-____-____

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

Return Completed Form on or before May 1st to your trip leader.
Trip Leaders will submit all forms to the Office of International Programs (OIP).