TO STUDENTS: Please complete the top section and questions 1-10 yourself and return the form directly to your on-campus sponsoring department/office at least one month prior to departure. DO NOT TAKE THE FORM TO YOUR FAMILY DOCTOR OR TO STUDENT HEALTH SERVICES.

TO CAMPUS SPONSORS: Forward the student’s form to Off-Campus Study, not to Student Health Services. Off-Campus Study will coordinate the review with Student Health Services.

Please not leave any blank spaces (you may write “None” where appropriate). The information you submit will be used solely as an aid to providing necessary health care. This form will be reviewed by the Student Health Center and recommendations made about participation. This form will be available to the Colgate faculty member or administrator accompanying your group, if you are participating in group travel. It will not be released to anyone else without your prior knowledge and consent. Please be aware that your medical records at Colgate University are confidential and will remain on campus while you are away.

Name: ____________________________________ Today’s Date: ________________________________
(Last)                           (First)                  (Middle Initial)

Destination ___________________________________ Campus Sponsor: ___________________________

Dates of Travel From __________________ To ___________________ (Please provide even if tentative)

NOTIFY THE COLGATE SPONSOR AND THE DIRECTOR OF OFF-CAMPUS STUDY IF YOU ARE EXPOSED TO ANY COMMUNICABLE DISEASES (E.G. CHICKEN POX, HEPATITIS, ETC.) AND/OR HAVE ANY ILLNESSES, INJURIES OR OTHER CONDITIONS AFTER COMPLETION OF THIS FORM, WHICH MUST BE ON FILE IN THE OFF-CAMPUS STUDY OFFICE BEFORE YOU LEAVE.

1. OPERATIONS – Please list dates and results.

2. CHRONIC ILLNESSES – Please indicate type, duration, treatments, limitations, and/or ongoing health needs.

3. HOSPITALIZATIONS – Please indicate type duration, treatments, limitations, and/or ongoing health needs.

4. RECENT ILLNESSES – (within the past year) – Please indicate type, duration, treatments, limitations, and/or ongoing health needs.

5. ALLERGIES – Please list all allergies, including those to food, medications, insect bites or bee/wasp stings, environmental exposure, etc. Please indicate if you are taking any allergy medicines (tablets, inhalers, injections—either over-the-counter and/or prescription, etc.)

6. PHYSICAL AND/OR LEARNING DISABILITIES – Please indicate type, duration, treatments, limitations and/or ongoing needs. Also, if you receive accommodation on campus for a physical and/or learning disability, please describe the nature of the accommodation.
7. **DIETARY RESTRICTIONS** – If so, please indicate type.

8. **OTHER** – Please answer yes or no (and further describe if yes)
   a) Treatment or problems associated with drug/alcohol/chemical abuse or dependency).
   
   b) Psychiatric/Psychological treatment or counseling.
   
   c) Eating Disorders (anorexia, bulimia, compulsive overeating).

9. **MEDICATIONS** – (prescription and/or over-the-counter) – Please list names and health problem being treated. *REMEMBER you will need to bring with you supply of any medications for the entire duration of your stay off campus.

10. Do you have, or have you had, any other health issues, conditions or problems which we should be aware of? If so, please explain.

The medical information provided above is complete and true to the best of my knowledge. I recognize that falsification or omission of information may jeopardize my own health and safety as well as that of other group members and could be grounds for non-participation (dismissal from the group).

Student Signature ___________________________ Date _________________________

**MEDICAL APPROVAL – TO BE SIGNED BY THE STUDENT HEALTH CENTER**

“I have reviewed this applicant’s records and I believe that his/her physical and mental health will permit him/her to participate in this particular event off campus both domestically and abroad. Attached is a copy of this applicant’s immunization record.”

Physician Signature ___________________________ Date _________________________

Merrill Miller, MD-
Colgate Student Health Center
13 Oak Drive
Hamilton, New York 13346
Tel: 315-228-7750
Fax: 315-228-6823

**COMMENTS:**

*Revised 5/10*