Medical Information & Emergency Contacts Form

PURDUE UNIVERSITY CALUMET

Student Name: _____ PUID #: _____

Program: _____ Term: _____

Age: _____ Date of Birth (month/day/year): _____

Weight: _____lbs (pounds) Height: _____feet _____inches

Sex: ☐ Male ☐ Female For treatment purposes, my religion is: _____

1. Have you had allergic reactions to any of the following? (check all that apply and provide additional information as needed)

   ☐ Hay fever ☐ Bees/wasps ☐ Pet/animal dander

   ☐ Foods: _____ ☐ Other: _____

   Please provide further information for any of the allergies identified above. Include medicines, foods, animals, insect bites and stings, and environmental factors (dust, pollen, etc.). Use a separate sheet if necessary.

Allergy	Reaction	Medication Required (if any)

2. Please list all prescription, over-the-counter, and natural medications you are taking or plan on taking while abroad. Use a separate sheet if necessary.

Medication Name	Dosage	Frequency	Side Effects (known and potential)	Reason for Taking

3. Have you ever been hospitalized for illness or operation or had a serious acute illness? If yes, give diagnosis and date. ☐ Yes ☐ No

   _____

4. Are you pregnant? If yes, give due date and information on any concerns/complications. ☐ Yes ☐ No

   _____

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5. Do you have now or have you ever had any of the following: (check all that apply and provide additional information as requested)

- ☐ Abdominal Pain
- ☐ Arthritis
- ☐ Back Problems
- ☐ Cancer or Leukemia
- ☐ Diabetes
- ☐ Endocrine Disorders
- ☐ Glaucoma
- ☐ Gynecological Problems
- ☐ Hernia
- ☐ Hypertension
- ☐ Impaired Use of Any Limbs
- ☐ Migraine/Severe Headaches
- ☐ Pain or Pressure in the Chest
- ☐ Physical Handicaps
- ☐ Renal Problems
- ☐ Ulcers
- ☐ Unusual Bleeding/Clotting
- ☐ Anemia
- ☐ Anxiety Reactions/Panic Attacks
- ☐ Bladder/Kidney Problems
- ☐ Cardiac/Heart Problems
- ☐ Chronic Indigestion, Diarrhea
- ☐ Epilepsy (Seizures)
- ☐ Eye Trouble (beyond needing normal corrective lenses)
- ☐ Hearing Loss
- ☐ High Blood Pressure
- ☐ Immune System Problems
- ☐ Learning Disability
- ☐ Neurological Disorders
- ☐ Painful Swollen Joints, Bones, or Muscles
- ☐ Psychiatric Disorders (including Eating Disorders)
- ☐ Recurrent Dizziness/Faintness
- ☐ Tuberculosis, asthma, or other respiratory problems
- ☐ Other: _____

If you checked any of the conditions above, please explain in detail. Use a separate sheet if necessary.

_____

6. Do you have any chronic/recurrent illness? (check all that apply)

- ☐ Chronic or Recurrent Gastrointestinal Problems
- ☐ Chronic Skin Problems
- ☐ Other: _____

If you checked any of the conditions above, or have any other permanent/chronic injury or physical disability, please explain in full detail. Use a separate sheet if necessary.

_____

7. Do you have any health requirements or dietary restrictions? If yes, explain. ☐ Yes ☐ No

_____

8. Do you have any medical issues that might affect your participation in the Program? If yes, please explain.

☐ Yes ☐ No _____

9. The Program may require vigorous activity, extended walking or hiking, and other physically and mentally demanding exertion in isolated areas without medical facilities, medical providers, or means of contacting rescue or medical personnel. Do you have any physical or mental limitations/restrictions of which you are aware? If yes, please explain. ☐ Yes ☐ No

_____

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10. In the last two years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional for any mental, emotional or psychological conditions including eating disorders and substance abuse? If yes, give details. ☐ Yes ☐ No

_____

11. Do you currently receive any medical treatment which would have to be continued while abroad? If yes, give details. ☐ Yes ☐ No

_____

12. Have you had any significant condition which is currently in remission? If yes, give details. ☐ Yes ☐ No

_____

*****If you answered "yes" to questions #10-12, the physician(s) primarily responsible for your care must fill out the appropriate supplemental form "Further Health Information for Overseas Travel." Forms are available for both mental health professionals (question #10) and medical professionals (questions #11 & #12).*****

The information requested below is sought to assist Purdue University Calumet officials and inform them of your emergency contact information in the unlikely event of an emergency during your international experience.

Primary Contact (to be contacted in case of an emergency):

Name: _____ Relationship: _____

Cell Phone #: _____ Alternate Phone #: _____

E-mail: _____

Secondary Contact (in case primary contact cannot be reached):

Name: _____ Relationship: _____

Cell Phone #: _____ Alternate Phone #: _____

E-mail: _____

Agreement and Signature:

In the event of an emergency abroad, Purdue University Calumet may notify my emergency contact(s). In the event that I need medical care, hospitalization, or surgery while participating on the Program, I understand that every effort will be made to contact the emergency contact(s) listed on this form. In the case that my emergency contact(s) cannot be reached and/or an immediate decision about care or treatment needs to be made, I authorize Purdue University Calumet and the Program through their representatives, to secure any necessary

treatment. Purdue University Calumet may, but is not obligated to, take any actions it considers to be warranted under the circumstances regarding my health and safety.

As an applicant to the Program, I hereby agree to the disclosure of information requested in this form and I waive my right to doctor-patient confidentiality in the event that Purdue University Calumet, and/or any medical facility in Indiana or abroad requests my medical records during the course of my education abroad program. I also authorize the release by Purdue University Calumet or the Program of my health records or other medical information pertaining to me to my designated emergency contacts in the event of an emergency.

On rare occasions, an emergency requiring treatment in a hospital and/or surgery may develop. In most cases, administration of an anesthetic, treatment of injury, or operation upon an individual cannot be done without consent of the patient. In order to prevent a dangerous delay in an emergency situation where the Program is either unable to contact my parent or guardian, or if I am unconscious or otherwise unable to give my consent, I hereby authorize the Program representative to secure whatever medical treatment is deemed necessary, including administration of an anesthetic and surgery.

I hereby verify that all of the information contained in this form is accurate and complete and acknowledge that any failure to provide accurate and complete information, including notification to the International Affairs Office (IAO) of changes in my health affecting the accuracy or completeness of the information contained in this form, may result in my dismissal from the program. I agree to notify IAO of any material changes in my health that occur prior to the start of the Program or while on the Program.

_____

Printed Student Name

_____ _____

Signature Date

If student is under 18 years of age:

_____

Printed Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date