CENTRAL WASHINGTON UNIVERSITY

OFFICE OF INTERNATIONAL STUDIES AND PROGRAMS

MEDICAL FORM

STUDENT INSTRUCTIONS:

To ensure your well being while overseas, we ask that all CWU students complete and return the following medical history and information to CWU two months prior to the start date of their program. This form is divided into two parts: The *Student Authorization of Emergency Treatment* and the *Medical Practitioner Report*. The first section should be completed and signed by you, the participant. The second part is to be completed and signed by your chosen medical practitioner (nurse practitioner, physician's assistant, or family physician). Please read the following instructions carefully, paying close attention to detail. Failure to provide complete and accurate information on this form may result in the termination of your participation in the program. If you have questions, please contact the Office of International Studies and Programs at 509-963-3622.

- Fill in your name and program as indicated on both the *Student Authorization of Emergency Treatment* portion and the *Medical Practitioner Report* portion of this form.
- Read, sign and date the *Student Authorization of Emergency Treatment* waiver below.
- Schedule an appointment for a complete physical examination with a qualified medical practitioner. Please note that this exam needs to take place **within six months of the first day of your program.**
- Request that your medical practitioner *complete* and *sign* the *Medical Practitioner Report*.
- Once completed in full, send or fax -- this form to:

Study Abroad and Exchange Program
Central Washington University
400 E. University Way
Ellensburg, WA 98926-7407
Fax: (509) 963-1558

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STUDENT AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT

Participant's Name____ Program ________________________________

I, the undersigned, hereby affirm that I have provided complete and accurate answers regarding my physical and emotional history during this examination and also that I am fully aware of the possible consequences of falsification of this data as stated in this three page form.

I hereby authorize emergency treatment of myself, if, in the opinion of the faculty/advisor and/or attending physician, emergency treatment is necessary to safeguard my health.

Student Signature: ____ **Date:** ______________________

(Important: If the participant is under 18 years old, the parent or legal guardian must also sign below)

Parent Signature: ____ **Date:** ______________________

CENTRAL WASHINGTON UNIVERSITY
OFFICE OF INTERNATIONAL STUDIES AND PROGRAMS

MEDICAL PRACTITIONER REPORT

Participant's Name ____ Program ________________________________

Please evaluate the physical and mental health of the student listed above for their participation in a CWU study abroad program. It should be noted that a student will not be denied participation in a CWU program due solely to a physical or emotional condition unless it is of such a serious nature that it may prevent successful participation in the program or cause harm to fellow students. Information regarding a student's health is used by our overseas staff to anticipate what resources may be needed for students should health problems arise during the course of the program. *If a student answers 'yes' to any of the following questions, please comment on the nature of the condition and note its severity in the space provided for further explanation.* A brief description and listing of any medication the student is currently taking, and will be bringing overseas, is also useful for a student should they need to seek medical attention while abroad. *Thank you for your cooperation.*

Participant's General State of Health

Excellent__________ Good__________ Fair__________ Poor__________

Participant's Date of Birth: __________ Height: __________ Weight: __________

Date of Examination: _________________________________

1. Is the participant seriously underweight or overweight? Yes________ No________

2. Does the participant have any dietary restrictions or food allergies: Yes________ No________

3. Is the participant allergic to any form of medication? Please Specify. Yes________ No________

4. Does the participant have any speech, hearing or eyesight impairments Which might affect his/her participation in the program? Yes________ No________

5. Does the participant have any physical disability which might cause hardship through change in diet, carrying luggage, or strenuous travel? Yes________ No________

6. Is there any congenital malformation now existing which may require additional treatment while overseas? If "Yes", what is this condition and what is to be pursued? (It should be noted that our insurance coverage does not include treatment for pre-existing conditions.) Yes________ No________

7. Is the participant currently under treatment or observation for any physical or emotional conditions? Yes________ No________

8. Is there any history of emotional disturbance in the participant? Yes________ No________
   Has the participant shown any signs of:

   a) Difficulties in relationships with parents, authority figures and/or peers? Yes________ No________
   b) A behavior disorder? Yes________ No________

(over)

c) An eating disorder? Yes________ No________

d) Symptoms such as mood swings, depression, severe sleep Disorders, unusual degrees of anxiety, fear or guilt? Yes________ No________

9. Does the participant have any communicable or infectious disease? Yes________ No________

10. To your knowledge, are there any predisposing medical, surgical, or emotional factors, which may, under stress or duress during the program present a need for immediate therapy for the participant while abroad? Yes________ No________

Please list and describe all prescription medications the participant is presently taking:

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Comments/Further Explanations:

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Medical Practitioner's Name: ____

Title: ____

Signature: ____ Date: ______________

Address: ____

____ Phone: (_______) ________________

Email: ____