Dear IUHPFL Parents, Guardians and Students,

The information collected with this Statement of Medical History will assist us in caring for students and maximize their safety while abroad.

IUHPFL requests full disclosure from students and their guardians on this form. Living overseas requires adjustments to different climates, diets, levels of physical exertion, and living environment – all of which can cause stress and exacerbate pre-existing conditions. Information regarding the student’s health is invaluable to the onsite staff in anticipating and dealing with any problems that might arise during the student’s stay abroad, particularly in case of an emergency. We thank you for taking the time to fill out this form as thoroughly as possible.

The information provided on this document will be shared with the IUHPFL instructor team and onsite coordinator. It will be shared with the student’s host family on a need-to-know basis.

Please e-mail us at iuhpfl@iu.edu or call 812.856.2123 with any questions. We ask that students and guardians be in contact with our office should a student’s medical or psychological condition change before departure.

Sincerely,
IUHPFL Office Team

Instructions for Completing the Statement of Medical History:

Part I: To be completed and signed by the student in conjunction with his/her legal guardian.
Part II: To be completed and signed by a Physician or Nurse Practitioner.
Part III (only if applicable): To be completed and signed by a Mental Health Care Provider

Students and guardians should work together to complete Part I of this form. Students should then take Parts I and II to their physical examination (or other doctor’s appointment). The form can be signed by a physician or nurse practitioner. A student’s legal guardian is encouraged to accompany him or her to the examination.

If applicable, students should then take Parts I, II and III to a session with their counselor, psychiatrist, or psychologist. A student’s legal guardian is also encouraged to accompany him or her to this session.

The physician or nurse practitioner completing Part II, as well as the counselor, psychiatrist, or psychologist completing Part III CANNOT be related to the student.

Because information on the Statement of Medical History may need to be shared with non-native English speakers, we ask that students, guardians, and doctors write legibly and with clarity.

Once the forms are complete and signed, they may be scanned and a PDF securely uploaded OR mailed. The form may be uploaded via the IUHPFL Website. Mail to: IUHPFL, 111 S. Jordan Ave., Bloomington, IN 47405. If you mail the form, please retain a copy for your records. This form is due March 1.
Statement of Medical History: Part I
To be completed by student and guardian

Student Name: _________________________________ Birthdate: ______________ Program Site: _________________

WE WISH TO DISCLOSE THE FOLLOWING PAST AND/OR CURRENT PHYSICAL OR MENTAL HEALTH CONDITIONS OR DISEASES (Please check all that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td>Acute/Chronic Bronchitis</td>
<td>Crohn's Disease</td>
<td>Mononucleosis/Pneumonia</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>Delusions/Hallucinations</td>
<td>Mouth/Teeth</td>
</tr>
<tr>
<td>Aggression (Acting Out, Fighting)</td>
<td>Depression</td>
<td>Obesity</td>
</tr>
<tr>
<td>Allergies - Drug</td>
<td>Diabetes</td>
<td>Obsessive/Compulsive Behavior</td>
</tr>
<tr>
<td>Allergies - Environment</td>
<td>Digestive System/Abdomen</td>
<td>Parasites</td>
</tr>
<tr>
<td>Allergies - Food</td>
<td>Drug/Alcohol Addiction</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td>Allergies - Pet</td>
<td>Dyslexia</td>
<td>Psychotic Disorder</td>
</tr>
<tr>
<td>Allergies - Smoke</td>
<td>Ears/Hearing</td>
<td>Recurring or Chronic Infections</td>
</tr>
<tr>
<td>Allergies - Other</td>
<td>Enuresis (Consistent Bed-Wetting)</td>
<td>Reproductive System Issues</td>
</tr>
<tr>
<td>Allergies - Severe (Anaphylaxis)</td>
<td>Epilepsy</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>Anorexia/Bulimia</td>
<td>Eyes/Vision</td>
<td>Scoliosis</td>
</tr>
<tr>
<td>Anxiety/Panic Attacks</td>
<td>Fears/Phobias</td>
<td>Seizures</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>Gastroesophageal Reflux Disease</td>
<td>Self-Injury</td>
</tr>
<tr>
<td>Asthma</td>
<td>Genetic/Chromosomal Condition</td>
<td>Skin Condition or Disorder</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>Grief</td>
<td>Sleep Disorder</td>
</tr>
<tr>
<td>Autoimmune Disease</td>
<td>Headaches/Migraines</td>
<td>Social Anxiety</td>
</tr>
<tr>
<td>Binging/Purging Food</td>
<td>Heart/Cardiovascular</td>
<td>Social Withdrawal</td>
</tr>
<tr>
<td>Blood Disorder</td>
<td>Hepatitis/Jaundice</td>
<td>Speech Problems</td>
</tr>
<tr>
<td>Bones/Joints</td>
<td>High/Low Blood Pressure</td>
<td>Suicide Attempt</td>
</tr>
<tr>
<td>Bowel/Intestine</td>
<td>Hyperactivity</td>
<td>Thoughts of Harming Self</td>
</tr>
<tr>
<td>Brain/Nervous System</td>
<td>Irritability/Mood Swings</td>
<td>Thyroid</td>
</tr>
<tr>
<td>Cancer/Tumors</td>
<td>Kidney/Urinary System</td>
<td>Tic Disorder/Tourette Syndrome</td>
</tr>
<tr>
<td>Chicken Pox/Shingles</td>
<td>Learning Disability</td>
<td>Tonsils/Nose/Throat</td>
</tr>
<tr>
<td>Chronic Fatigue Syndrome</td>
<td>Lungs/Respiratory System</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Malaria</td>
<td>Ulcer</td>
</tr>
<tr>
<td>Concussion</td>
<td>Measles</td>
<td>Vertigo/Dizziness</td>
</tr>
<tr>
<td>Cough (Consistent, Recurring)</td>
<td>Meningitis</td>
<td>Other:</td>
</tr>
</tbody>
</table>

1) For any items checked above, provide details and dates of treatment.

For any items checked above, does the student need treatment while abroad?  
Yes  No

If yes, discuss these treatment options with your physician and ask him/her to comment in Part II or, if applicable, Part III.
2) Has the student ever been hospitalized?  Yes  No
If yes, please explain (include dates):

3) Has the student ever been advised to have surgery that has not been done?  Yes  No
If yes, please explain:

4) Is the student currently receiving, or has the student recently received, medical or psychological care for conditions not listed above?  Yes  No
If yes, describe fully in the space below:

5) Does the student have any other ongoing emotional or physical conditions not listed above that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise?  Yes  No
If yes, describe fully in the space below:

6) Are the student’s immunizations up to date?  Yes  No
Students and parents should visit the CDC’s website (www.cdc.gov/travel) for the most up-to-date health information and vaccination recommendations regarding travel to their specific program country. Optional: Obtain and attach copy of International Certificate of Vaccination.
If no, please explain:

Medications
We strongly suggest that the student bring enough medication to last through all the weeks abroad. If this is not possible, ask your doctor for a typed prescription to fill abroad, and/or discuss with your doctor other possibilities for continuing your medication/treatment while abroad.

List all medications (prescription or non-prescription) and dosages the student will be taking while abroad (if you need more space, please attach a list): □ No medications □ All medications listed here □ List attached

7) The student has permission to take the following over-the-counter medications (check all that apply):

□ Aspirin  □ Benadryl
□ Acetaminophen (Tylenol)  □ Antacid (Tums)
□ Ibuprofen (Advil)  □ Other: ________________________________
□ Naproxen Sodium (Aleve)

8) To be initialed by Parent/Guardian:

_____ We understand that changes to prescriptions or medication dosages while abroad is not advised, however if a change is necessary, then the following steps will be required: 1) Letter from Indiana doctor with recommended change
2) All new medical information should be sent to the IUHPFL office, not to the host family or on-site staff.
**Eyesight**

9) Does the student wear glasses?  Yes  No  Does the student wear contact lenses?  Yes  No

We strongly suggest you contact your eye doctor to obtain a copy of your prescription for glasses and/or contact lenses and bring this information with you abroad.

**Disabilities and Other Accommodations**

IUHPFL complies with the Americans with Disabilities Act ("ADA") and engages in the interactive process required by the ADA to provide reasonable accommodations for eligible students. The first step in this process is disclosure and documentation of the condition(s). Conditions may include physical, psychological, learning, neurological, medical, vision, or hearing disabilities, and may include individualized education programs, 504 Plans, etc.

10) Please select one of the following options:
   - [ ] No accommodations are requested
   - [ ] Yes, we will be requesting accommodations and we will submit the “Reasonable Accommodations Request” form via the IUHPFL website

If you selected ‘yes’, please summarize your request for accommodation(s) here:

**Physician**

1) List the name of a physician in the United States who should be consulted in case of an emergency.

   Physician’s name: ___________________________________________ Phone: (_____)____________________

**Mental Health Provider** (if applicable*)

2) List the name of the mental health provider in the United States who should be consulted in case of an emergency.

   Mental Health Provider’s name: ___________________________________________ Phone: (_____)____________________

*If the student has a current mental health provider, or has seen one in the past year, his/her name and number should be provided above and Part III of this form must be completed by the mental health provider.

**Disclaimer regarding Disclosure of Medical and Psychological Conditions**

Parents, legal guardians, and students should understand that IUHPFL is more capable of dealing with pre-existing medical or psychological conditions of students, when those conditions are disclosed well in advance of the program, specifically on this Statement of Medical History. If a pre-existing medical or psychological condition of a student comes to light during the program and was not disclosed to IUHPFL prior to the start of the program, IUHPFL may return the student to the United States prior to the end of the program if IUHPFL determines, in its sole discretion, that the level of care or accommodation required for such a condition cannot reasonably be provided onsite. In such a case, the Parent/Guardian will be responsible for covering all expenses including but not limited to airfare, transportation, lodging and other costs associated with returning Student to the United States, as well as costs associated with having Student accompanied to the relevant international airport by an IUHPFL Program Instructor or other onsite authority.

**Consent**

We, the undersigned, grant Indiana University and its employees and agents full authority to act in an attempt to safeguard and preserve my health and safety during my participation in IUHPFL, including authorizing routine or emergency medical treatment on my behalf and at my expense and returning me to the United States at my own expense. I grant IU and its employees and agents the right to share my completed Statement of Medical History with the onsite coordinator, my host family, and medical personnel on an as-needed basis.

Student signature: ___________________________________________ Date: ______________________

Guardian signature: ___________________________________________ Date: ______________________
Statement of Medical History: Part II
Medical Consultation to be completed by a Physician or Nurse Practitioner (NP)

Student name: _____________________________ Date of birth: _________________ Program site:________________

This student has been accepted into the Indiana University Honors Program in Foreign Languages (IUHPL) and will be spending five to six weeks abroad in June and July. Living overseas can exacerbate pre-existing medical or psychological conditions, therefore any information you can provide regarding the student's health is invaluable in anticipating and dealing with any problems that may arise during the program, particularly in case of an emergency. *This form may need to be shared with non-native English speakers, so please write legibly and with clarity. The Physician or NP completing Part II must not be a family relation of the student.*

- Please review the completed Part I of this Statement of Medical History with the student and his/her guardian during a physical examination (or other appointment)
- Complete and sign Part II below and return both parts to the student
- Attach a copy of any notes that do not fit on this page

1. Are the student’s immunizations up to date?   Yes   No
   If no, please explain:

2. Please provide below your comments and recommendations, in regards to his/her physical health (past and current):

3. Please list any medications that the student is currently and/or will be taking while abroad and state their purpose:

4. Please list any kind of drugs (prescription or non-prescription) which should *not* be administered to the student while abroad due to allergies or other contraindications.

5. Should the student be restricted from any kind of physical activity while abroad?  Yes  No
   If yes, explain restrictions:

6. Your opinion of the student’s health:   Excellent  Good  Fair  Poor

7. Other comments:

*I, the undersigned, have reviewed the medical history of the student and given a thorough physical examination and certify that, to the best of my knowledge, all important medical information has been fully disclosed on this form and that nothing relevant has been omitted.*

Signature of MD or NP (Signing MD or NP must not be a family relation of the applicant):

Signature: ___________________________________________ Date: __________________

Name (printed): ___________________________________________ Phone Number: (_______) ________________

Address:___________________________________________________________________________________________________
Statement of Medical History: Part III
Behavioral consultation to be completed by the Mental Health Care Provider

Student name: ____________________________________ Date of birth: ___________ Program site:_______________

This student has been accepted into the Indiana University Honors Program in Foreign Languages (IUHPFL) and will be spending five to six weeks abroad in June and July. Living overseas can exacerbate pre-existing medical or psychological conditions, therefore any information you can provide regarding the student's health is invaluable in anticipating and dealing with any problems that may arise during the program, particularly in case of an emergency. This form may need to be shared with non-native English speakers, so please write legibly and with clarity. The Mental Health Care Provider completing Part III must not be a family relation of the student.

1) Please review the completed Part I and Part II of this Statement of Medical History with the student and his/her guardian during a session

2) Complete and sign Part III below and return both parts to the student

3) Review with the student the emotional/behavioral health history section he/she completed in Part I. Please advise the student of risks, health care needs, and medication needs while abroad.

4) Your opinion of the student’s emotional and mental health:   Excellent     Good        Fair         Poor

5) If the student has indicated “yes” to any of the mental health questions in Part I, and also needs to continue treatment while abroad, please explain your recommendations for treatment in the space below.

6) Other comments:

I, the undersigned, have reviewed the medical history of the student and given a thorough consultation and certify that, to the best of my knowledge, all important medical information has been fully disclosed on this form and that nothing relevant has been omitted.

Signature of Mental Health Care Provider (Mental Health Provider must not be a family relation of the applicant):

Signature: ____________________________________________ Date: __________________________

Name (printed): ____________________________________________________ Phone Number: (_____) ________________

Address:

Street Address __________________________________________ City __________ State ______ Zip Code______

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