Health Form
for
Students on Bucknell
Study Abroad Programs

Since a program of study abroad can be both physically and emotionally stressful, we ask that you provide a frank evaluation of your health. University compliance with the American Disabilities Act ensures that no one can be denied acceptance to a study abroad program for reasons of health, unless reasonable accommodations are not available. The following information is considered confidential and will be used only by the program director in an attempt to provide reasonable accommodations for your condition while you are abroad.

You may have the medical examination done at the Zeigler Health Center at no charge; appointments with the physician can be easily scheduled. Return this in an envelope marked "confidential" to your program director.

Medical Information

Name: (please print) _____
Last First

BU ID#/Social Security #:_____

Semester Abroad: Summer 20_____

Program_____**Bucknell in Northern Ireland**_____

Gender: M_____ F_____ Height: _____ Weight:_____

I authorize the academic director(s) of **Bucknell in Northern Ireland** (name of program) to contact the following individual(s) to discuss any medical or health condition which may arise while I am abroad.

Name_____ _____
Student Signature

Address_____

_____ _____
Date

Phone #_____

If you answer YES to any of the following questions, please use a separate sheet of paper to give details of the condition and the treatment you received or are continuing to receive.

1. Are you currently under medical treatment? ___No ___Yes (explain)

2. Are you currently taking any medication? ____No ___Yes (explain and name medication)

3. Is this medication for a _____ temporary or _____ ongoing condition?

Are you allergic to any medication?_____ No _____Yes (explain)

4. Please list any dietary restrictions/preferences.

5. a. Please list any allergies, food or other.
   b. Are you allergic to any medication? ____No ____Yes (explain)

6. Have you ever been or are you currently being treated by a psychologist or physician for a significant emotional disorder requiring hospitalization or medication? _____No_____Yes (explain)

7. Do you or might you have an eating disorder? _____No _____Yes (explain)

8. Have you had a previous eating disorder? ____No ____Yes (explain)

9. Do you have a history of drug or alcohol abuse? _____No _____Yes (explain)

10. Do you have any learning disabilities or physical impairments? _____No _____Yes (explain)

11. Are you pregnant or do you have any reason to suspect you might be? _____No _____Yes (explain)

12. Have you had any diseases or significant injuries? _____No _____Yes (explain)

l3. Have you had any surgical operations or been advised to have any? _____No _____Yes (explain)

14. Is there anything else about your health or medical history that we should know which may be a factor should there be an emergency? _____No _____Yes (explain)

I certify that the information on this Medical Information Form is true and correct

and understand that it will only be used for the purposes for which it was prepared.

_____ _____

Student Signature Date

Part II: To be completed by physician

I have read Part I and have examined this patient. To the best of my knowledge, I recommend that the student

_____ participate without restriction

_____ participate only if the following care can be reasonably accommodated:

Signature of Physician:_____

_____ _____
Printed Name of Physician Date of Exam

Address:_____
Street
_____
City State Zip

_____
Telephone Number For Physician's Stamp