HUTTON HONORS COLLEGE
HUTTON INTERNATIONAL EXPERIENCES PROGRAM

Medical History Form

Name _____ Overseas Study Program _____
(print)

Please provide below information that will help our staff overseas obtain medical assistance for you in the case of accident or illness. Language barriers and incomplete medical records can delay treatment. It is therefore important that you provide any information that might be relevant in a medical emergency.

1. Are you currently receiving, or have you recently received any medical or psychological care of which you want us to be aware in case of an emergency? If so, describe fully.
   _____
   _____
   _____
   _____

2. List any other on-going physical or emotional conditions which might require treatment abroad, or that might be exacerbated by changes in climate, diet or exercise. What treatment is recommended?
   _____
   _____
   _____
   _____

3. What medications or other substances are you allergic to? _____

4. Are you on a medically restricted diet? If so, give details._____
   _____

5. Overseas Study endeavors to provide reasonable accommodations for students with *documented* disability conditions (e.g., physical, learning, etc.). If you are receiving disability-related accommodations at IU or anticipate needing them at your overseas site, attach documentation confirming the disability and information about accommodations currently provided at IU (e.g., a letter from Disabled Student Services). Provide details relevant to your request for accommodation(s) abroad on a separate sheet

   (If you choose not to disclose disability related needs prior to the program, IU will not be able to assist you in arranging special accommodations.)

6. Do you have a physician who should be consulted in case of an emergency? If so, list below.
   Physician's name_____ Phone (____)_____

   I grant IU, its employees, agents and consortium partners full authority to act in an attempt to safeguard and preserve my health and safety during my participation in the program abroad, 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.

_____ _____
Signature *Date*

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