HEALTH / MEDICAL REPORT

PERSONAL INFORMATION

Full Name (As on passport):			
Date of Birth:			
Passport Number:		Gender:	Male Female
Citizenship:			
Principle Address			
Home Phone:		Cell Phone:	
Email:			

EMERGENCY CONTACTS

You must provide two emergency contacts. Please check that these people will be available while you are on the semester in case we need to contact them. Your contacts should not be individuals who are traveling with you.

Full Name:			
Relationship to you:			
Home Phone:		Cell Phone:	
Email:			

Full Name:			
Relationship to you:			
Home Phone:		Cell Phone:	
Email:			

HEALTH DECLARATION

The Health Declaration is a vital part of this form. This section also requires your signature.

- Please answer the questions in the participant portion of this section accurately, including as much detail as possible so that we can determine your suitability to the coastal semester and can accommodate you to the best of our ability
- Accurate completion of this Health Declaration will be helpful if you have a medical emergency while on the semester. You must alert coastal staff of any changes to your medical status or medications that occur after submission of this Health Declaration.

Height (ft/in):		Weight (lbs):	
If under- or overweight, by how much? (lbs)			

Have you ever had any of the following conditions? Please check all that apply and provide as much additional detail as possible for any condition you have. Your form will not be considered complete without this requested information.

Anemia	☐	Epilepsy / Seizures	☐	Migraines/Severe Headaches	☐
Cancer	☐	Head injury	☐	Musculoskeletal conditions (osteoporosis, fibromyalgia, etc.)	☐
Chronic lung conditions	☐	Heart conditions (including disease, murmur, irregularity)	☐	Nervous system conditions (multiple sclerosis, Parkinson's, etc.)	☐
Chronic back conditions	☐	Heat and/or cold sensitivity	☐	Orthopedic problems (sprains, strains or fractures)	☐
Cognitive disorders (Alzheimer, memory loss, dementia, etc.)	☐	High blood pressure	☐	Skin conditions	☐
Dizziness/balance conditions	☐	Immune system conditions	☐	Sleep apnea	☐
Eating disorder	☐	Kidney or liver conditions	☐	Stomach/intestinal conditions	☐
Endocrine/thyroid conditions	☐	Malaria	☐	Tuberculosis/exposure to TB	☐
Lyme disease	☐	Fainting spells	☐	Other (please specific below)	☐

Additional Information: Append additional paper if this space is not sufficient.

Asthma	☐	Cause:		Do you self-medicate	Yes ☐ No ☐
Diabetes / Hypoglycemia	☐	Cause:		Do you self-medicate	Yes ☐ No ☐
Active Hepatitis:	☐	Type:			
Have you been hospitalized or had surgery in the past two years? If yes, please include provide as much detail as possible in the space below.					Yes ☐ No ☐
Do you have any phobias which might inhibit your participation? If yes, please describe in the space provided below.					Yes ☐ No ☐
Do you have any allergies? Include drugs, food, insect stings etc. If yes, list the type of reaction, the severity, and required treatment. Please indicate any medications you will be carrying to treat your allergy.					Yes ☐ No ☐
Do you have any conditions that are not already indicated on above?					Yes ☐ No ☐
If you have any of the conditions listed above, please provide as much detail as possible here, including dates of treatment/surgery, and potential effects on your participation on this project.					

We may need to contact you to discuss your condition to assess how it may affect your ability to safely and effectively participate on the coastal semester.

MENTAL HEALTH – This information is private and will never be shared publicly.

Have you ever been diagnosed with or been treated for a psychiatric condition such as bipolar disorder or depression? If yes, please provide details:	Yes No
Have you ever been hospitalized or in residential treatment for psychiatric care? If yes, please provide the dates of hospitalization/treatment:	Yes No
Do you suffer from claustrophobia, anxiety, ADHD or other related conditions for which you take medication of any sort? If yes, please provide details below.	Yes No
May we contact your psychologist/psychiatrist? If yes, please provide name and number below:	Yes No

MEDICATIONS

Do you take or have you ever taken any prescription or non-prescription medications for any reason? If yes, please list the medication, reason for taking it, length of time you have been taking it, and the current dosage.	Yes No

Medication	Reason for taking	Date started	Dosage
Please add any additional information here:			

INSURANCE INFORMATION

Medical Insurance Company	
Policy #:	Group #:
Are you the primary policy holder?	Y ◯ N ◯
If NO please provide the following	
Name of Primary Policy Holder	
Date of Birth	
Social Security Number of Policy Holder (if not yourself)	Last 4:

PARENT OR LEGAL GURADIAN SECTION

(*Must be filled out if student is under 18 years old.)*

THE LAW requires that parental permission be obtained for procedures on minors. The following consent form should be signed by a parent or guardian so that such procedures may be promptly carried out with no unnecessary delays. However, no major operation will be performed, except in extreme emergency, without parents being contacted and fully informed.

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter/ward. I also give permission for information to be released to my insurance company as deemed necessary.

Signed _____

Relationship _____ Date _____