

Medical Forms

for study abroad in Heidelberg, Germany

STUDENT: Please complete both pages of the Medical History Questionnaire before your physician's appointment. The Physical Exam and Health Clearance Form must be signed by the examining physician and returned to the AJY Office at Heidelberg University in Tiffin, Ohio, before participating in the AJY program.

PHYSICIAN: The student, whose name is listed on the attached Physical Exam and Health Clearance Form, has been selected to participate in a semester, year, or summer of study at the University of Heidelberg in Germany in a program sponsored by Heidelberg University, Tiffin, Ohio.

Living and studying in a foreign environment frequently creates unexpected physical and emotional stress, which can exacerbate otherwise mild disorders. Rather than alleviate symptoms of problems experienced at home, study abroad can often magnify these problems.

A Health Clearance is required for participation in the AJY program. Please note that:

- 1. The student must present you with a fully completed AJY Medical History Questionnaire. Please review this form carefully with the student for accuracy and completeness. Of particular relevance are immunizations that may be needed, allergies the student may have, and all currently active health problems.
- 2. Special attention should be paid to any emotional or psychological problems and the medications the student is taking. The AJY program is especially concerned for the well-being of students who are anorexic or bulimic and those who have bi-polar disorders or depression that require medication, as these conditions may escalate in a foreign environment. Students may be cleared with these conditions provided they are in compliance with and stabilized on their medication.
- 3. Students should be made aware of the need to ascertain the availability in Germany of medications they are taking and/or to assure that they have an adequate supply of any medications needed. The need for counseling or laboratory testing while abroad should also be determined so that the AJY program can make possible arrangements on site.
- 4. Physical or learning disabilities should be noted on the form along with indications of the facilities or services required abroad, so that the AJY program can make possible arrangements on site.

Students may be cleared for participation so long as, in the opinion of the examining practitioner, any medical condition they may have is under control and they have been stabilized on their medication for a reasonable period of time.



Medical History Questionnaire

Name			_Country of Birth		
Last	First	Middle	_		
Birth Date (MM/DD/YYY	Y)				
Parent(s)/Guardian(s)		Student's Univers			
	Name				
Home Address		Parent's Work Pl	Parent's Work Phone Number(s)		
City	State	Zip Code	Home Phone		
Family Physician			<u> </u>		
Name			Phone #		
Emergency Contact (for t	he U.S.)				
	Name	Home P	hone #	Work Phone#	
Emergency Contact in Ge	rmany (if available)				
	Name		Address		
Home phone#		Work phone #	Relationship		
ALLERGIES					
CURKENT MEDICATIO	PNS/SUPPLEMENTS/PRES	CKIPTIONS			

Past Medical History

If you have ever had or presently have any of the following conditions, please check the appropriate area with age noted.

Infectious Disease	Yes/Age	Neurological	Yes/Age	Gastro-Intestinal	Yes/Age
Tuberculosis		Headaches/Migraines		Ulcer/Ulcerative Colitis	
Other		Dizziness		Hernia	
Eyes, Ears, Nose		Epilepsy		Hepatitis/Liver Disease	
Blurred Vision		Head Injury/Concussion		Genital-Urinary	
Glasses/Contacts				Bladder Disease	
Other		Heart & Lungs		Kidney Disease	
Hematologic		Heart Murmur		Kidney Stone	
Anemia		High Blood Pressure		Musculoskeletal	
Blood Disorder		Shortness of Breath		Bone Fracture	Area:
Metabolic		Asthma		Back Problem	
Diabetes		Palpitations		Joint Deformity	Area:
Thyroid Problem		Exercise Induced Asthma		Knee Problem(s) Rt/Lt	
Hypoglycemia		Other		Other	
ADHD				Hospitalization	
Females Only		Males Only		Psychiatric Care	
Menstruation		Prostate Gland Disorder		Disordered Eating	
Painful		Testicular Disease/Disorder		Extreme Wt. Loss/Gain	
Irregular		Smoking		Anxiety	
Duration		Alcohol Use		Depression	

If YES to any of the above, please provide an explanation in the Notes section on page 3.

Immunization Record ***REQUIRED***

(**) Please note that the immunization record below must be completed in its entirety.

**M.M.R. (Measles, Mumps, Rubella) (Two doses REQUIRED after 12 months of age-need childhood dates)	M D Y	M D Y			
**TETANUS-DIPHTHERIA IMMUNIZATION (Include childhood dates and at least 1 booster date within past 9 years- REQUIREMENT)	#1	DTaP/DPT #2 M D Y	#3	DTaP/DPT #4 M D Y	**Tetanus Td/TDaP Booster (most recent booster must be within the past 9 years) / M D Y
**POLIO IMMUNIZATION (Primary series in childhood meets REQUIREMENT).	#1 N D Y	#2	#3	#4 M D Y	
**CHICKEN POX History of chicken pox disease, positive antibody test OR documented vaccination dates meet the REQUIREMENT.	History of Disease Yes or No Age of disease yrs. old	Positive Antibody Titer Y or N M D Y	Date of Vaccine (If no history of disease) #1 M D Y	Date of Vaccine #2 M D Y	
**HEPATITIS B (3) doses meet the REQUIREMENT.	#1	#2	#3		
**TUBERCULIN SCREEN & MANTOUX TEST REQUIREMENT Have you ever had a positive TB skin test? Yes / No	Have you ever had close contact with anyone who was sick with TB? Yes / No	Were you born or have you traveled to a country with a high rate of TB? Yes / No If yes, where?	Have you been vaccinated with BCG in an international country?	Have you ever had a positive TB skin test? Yes / No	**Tuberculin (PPD- MantouxTest) Date Given / Date Read // Resultsmm Neg./Pos
MENINGOCOCCAL MENINGITIS A, C, Y, W-135 (STRONGLY RECOMMENDED)	Menactra or Menomune				
NOTES (Explanations for "yes") <u>:</u>			
I hereby certif	y that all informat	ion I have provided	l is true and correct	to the best of my	knowledge.
Student Signature Date					

PHYSICAL EXAM* & HEALTH CLEARANCE FORM

NAME		DATE OF BIRTH	_AGE_		
HEIGHT	WEIGHT	% RODY FAT (ontional)	AGE PULSE		
BP /	wEiGIII		I OLSL		
VISION R 20/L 20/	CORRECTED:	YN PUPILS:	EQUALUNEQUAL		
Notes:					
MEDICAL	NORMAL	ABNORMAL	FINDINGS		
Appearance					
Eyes/ ears/ nose/ throat					
Hearing					
Lymph nodes					
Heart					
Murmurs					
Pulses					
Lungs					
Abdomen					
Skin					
MUSCULOSKETAL					
Neck					
Back					
Shoulder/arm					
Elbow/forearm					
Wrist/ hand/fingers					
Hip/thigh Knee					
Leg/ankle					
Foot/toes					
1 000 1003					
Pre-existing Medical/Emotiona	al Conditions:				
HEALTH CLEARANCE					
			are and/or after a physical examination, I		
have determined that (check O	11.5		11. 1. 11		
		e American Junior Year/Heidelberg			
Cleared, with restrictions	(i.e. physical activities) or i	recommendations for further evalua-	mon/treatment. Comments:		
Not cleared for study abroad Reason:					
That cleared for study using	Trouson.				
SIGNATURE					
STOTATIONE					
For what length of time have	you treated the student?				
I have read the information about the rigors of study abroad and have reviewed the health history with the student.					
Printed name of Physician:		I	Phone:		
Signature of Physician:]	Date Completed:		
*Chiropractic Examination is not ac	ccepted.		•		