EVERGREEN
THE EVERGREEN STATE COLLEGE
OLYMPIA, WASHINGTON

Study Abroad Medical History

Name _____ Birth date _____ Phone Number _____

Address: _____
STREET CITY STATE ZIP

Insurance Carrier _____ Policy Number _____

Physician _____ Phone Number _____

Medical History of Participant: Please answer the following questions to the best of your knowledge.

NO YES

☐ ☐ Do you have any physical complaints, chronic illnesses or psychological problems at this time? If yes, please describe _____

☐ ☐ Have you had injuries in the past (back, knee, shoulder, elbow, etc.)? If yes, please describe _____

☐ ☐ Are you currently under the care of a physician or practitioner, counselor or psychologist of any kind? If yes, please describe _____

☐ ☐ Are you taking medicines? If yes, what dosage _____

☐ ☐ Are you on a special diet? If yes, specify _____

Do you have, or have you ever had:

☐ ☐ Diabetes If yes, are you taking insulin ? _____ How much? _____

☐ ☐ Seizures

☐ ☐ Asthma

☐ ☐ Allergies, Please Specify _____

☐ ☐ Allergies to bee stings? Type of reaction _____

Please specify any other medical conditions. _____

_____

_____

_____

_____

I approve of emergency care for myself, or the above minor, under the direction of the event leader or consulting doctor, if I am unable to make my wishes known. (Cross out the above statement if you do not wish to grant medical consent.) I have filled out the above section to the best of my knowledge. If I am an adult, I read and understand the risks of exercise information and have consulted a physician if I have any cardiac risk.

Signature _____ Date _____