



## Santa Clara University Required Form #2: SCU Health Report

### INSTRUCTIONS FOR PROGRAM COORDINATORS:

SCU Faculty/Staff Program Coordinators will keep a copy of this document with them for the duration of the program and may use in the event of an emergency. SCU Faculty/Staff Program Coordinators will shred paper forms upon completion of the program.

### INSTRUCTIONS FOR PARTICIPANTS:

All students planning to participate in a Santa Clara University international or off-campus program must complete this form by themselves after they have received notification of acceptance and have decided to confirm their offer to participate on the SCU program. Some programs will require additional vaccinations, medications, health exams, or medical forms. Submit this signed and completed form to your SCU Faculty/Staff Program Coordinator.

As a reminder to you, you agreed to the following related to this SCU Health Report when you signed the Santa Clara University Required Form #1: SCU Waiver:

- I agree to notify the program coordinator of any relevant changes in my health that occur prior to the start of the program or while on the program off-campus.
- I understand that the stress of navigating a new culture may require me to manage my health in new ways during the program and that I am responsible for initiating and accessing resources available to support me off-campus.
- I understand that it is my responsibility to work with my Program Coordinator to identify an appropriate program off-campus in keeping with my documented needs.
- I understand that I should discuss with my medical professional the potential implications for my on-going medications and any new medications required abroad.
- I understand that it is my responsibility to determine how to bring or obtain my regular medications off-campus and that if my program is outside of the US I should refer to the embassy information for the country(ies) in which I will travel to determine whether my medications are legal and what quantities I may bring.
- I understand that I should bring medications in their original packaging in my hand luggage and that I should bring a copy of the prescription.

Name: \_\_\_\_\_ SCU ID# (if applicable): \_\_\_\_\_

Program Name: \_\_\_\_\_ Program City/Country: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex/Gender: \_\_\_\_\_

### HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Health Care Provider's Email: \_\_\_\_\_

### GENERAL HEALTH

My general health is:  Excellent  Good  Fair  Poor

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

List any physical or emotional condition, disability, or impairment that might cause hardship during a period of strenuous travel, study, or extended stay abroad: \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

**IMMUNIZATION HISTORY: Indicate most recent date of immunization.**

	Date		Date
DPT		Measles, Mumps and Rubella (MMR)	
Polio		Meningitis	
Hepatitis A		Typhoid	
Hepatitis B		Tetanus or Tetanus/diphtheria	
Yellow Fever			

Name of COVID-19 Vaccine	Date of Shot #1	Date of Shot #2
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**MEDICAL HISTORY**

List any history of abnormal mood swings, behavioral disorders, or emotional disturbances: \_\_\_\_\_

List any known allergies to medications or vaccines: \_\_\_\_\_

List any food allergies or dietary restrictions: \_\_\_\_\_

Mark any of the following which you may have had and explain any recent or serious episodes:

- |                    |                 |                 |                  |
|--------------------|-----------------|-----------------|------------------|
| Allergies          | Diphtheria      | Malaria         | Scarlet Fever    |
| Amoebic            | Drug/Alcohol    | Measles         | Severe Headaches |
| Appendicitis       | Addiction       | Menstrual       | Sinusitis        |
| Asthma             | Ear Infection   | Migraine        | Smallpox         |
| Bronchitis         | Eating Disorder | Mononucleosis   | Stomach Ulcer    |
| Bone Infection     | Epilepsy        | Mumps           | Surgery          |
| Chicken Pox        | Eye Trouble     | Muscle/Joint    | Tuberculosis     |
| Depression         | Hay Fever       | Pneumonia       | Typhoid Fever    |
| Diabetes           | Heart Trouble   | Poliomyelitis   | Whooping Cough   |
| Digestive Problems | Hepatitis       | Rheumatic Fever |                  |
|                    | Kidney Trouble  |                 |                  |

Please list and explain any serious illnesses you have had not covered above: \_\_\_\_\_

Are you receiving Physical or Learning Accommodations? Explain and forward accommodations email/documentation from Disability Resources to Program Coordinator: \_\_\_\_\_

Please note any other information, including details of any current treatment, which could be helpful to a physician who would treat you while off-campus (attach additional narrative, if necessary): \_\_\_\_\_