Hypothetical City College Study Abroad Program
Medical/Health History and Immunization Record

Student Information

Full Name: _____

Student ID (NetID): _____

Date of Birth (M/D/Y): [___] / [___] / [_____]

Emergency Contact Information

Emergency Contact Name: _____

Relationship to Student: _____

Phone Number(s): _____

Email Address: _____

General Health Information

1. **Do you have any chronic medical conditions or allergies?**
   ☐ Yes ☐ No
   If yes, please describe: _____

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2. **Do you take any prescription medications?**
   ☐ Yes ☐ No
   If yes, please list medications and dosages:

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3. **Do you have any over-the-counter medications or supplements you regularly take?**
   ☐ Yes ☐ No
   If yes, please list them:

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4. **Do you have any history of mental health conditions (e.g., anxiety, depression)?**
   ☐ Yes ☐ No
   If yes, please specify: _____
5. **Do you have any physical or mobility limitations that could impact your participation in the program?**
   ☐ Yes ☐ No
   If yes, please describe: _____

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6. **Do you have any dietary restrictions or preferences?**
   ☐ Vegetarian ☐ Vegan ☐ Gluten-Free ☐ Other (please specify): _____
   ☐ None
7. **Do you have any recent surgeries or medical treatments that could affect your participation?**
   ☐ Yes ☐ No
   If yes, please describe: _____

Immunization Record

Please ensure all immunizations required for international travel are up-to-date. Include dates of immunization.

Required Immunizations for Study Abroad

The following immunizations are typically recommended or required for international travel. Please indicate the date(s) of vaccination and whether you have received the immunization.

1. **Measles, Mumps, and Rubella (MMR)**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____
2. **Tetanus, Diphtheria, and Pertussis (Tdap)**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____
3. **Hepatitis A**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____

4. **Hepatitis B**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____

5. **Varicella (Chickenpox)**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____

6. **Polio**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____

7. **Meningococcal**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____

8. **Influenza (Flu)**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____

9. **Typhoid**
   ☐ Yes ☐ No
   Date(s) of Immunization: _____

10. **Yellow Fever** (Required for some countries)
    ☐ Yes ☐ No
    Date(s) of Immunization: _____

11. **Rabies** (Optional, but recommended for certain regions)
    ☐ Yes ☐ No
    Date(s) of Immunization: _____

12. **COVID-19**
    ☐ Yes ☐ No
    Date(s) of Immunization: _____

13. **Other Vaccinations or Immunizations**
    Please list any additional vaccines you have received:

Medical Consent and Acknowledgment

In the event of an emergency, I authorize Hypothetical City College and its designated representatives to seek medical attention on my behalf and to share this medical information with healthcare providers as necessary. I understand that it is my responsibility to ensure that my immunizations are up-to-date before departing for the Study Abroad Program.

I hereby consent to the use of this medical information by program administrators for the purposes of ensuring my health and safety during the program.

Student Signature: _____

Date: _____

Parent/Guardian Signature (if under 18): _____

Date: _____