

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

## **Student Information**

Full N	ame:			
Stude	nt ID (NetID):			
Date o	of Birth (M/D/Y): [] / []			
Emerge	ency Contact Information			
Emerge	ency Contact Name:			
Relatio	nship to Student:			
Phone Number(s):				
Email A	Address:			
Genera	Il Health Information			
1.	Do you have any chronic medical conditions or allergies?			
	☐ Yes ☐ No If yes, please describe:			
2.	Do you take any prescription medications?			
	☐ Yes ☐ No			
	If yes, please list medications and dosages:			

3.	Do you have any over-the-counter medications or supplements you regularly take?  ☐ Yes ☐ No			
	If yes, please list them:			
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:			
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:			
Please	nization Record ensure all immunizations required for international travel are up-to-date. Include dates of			
immur	nization.			
Requir	ed Immunizations for Study Abroad			
	llowing immunizations are typically recommended or required for international travel. Please e 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:	_
	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 1	8):	 
Date:		