

# BSC Office of International Programs Participant Medical Report

**Return to the Office of International Programs, Maxwell Library, Room 100B, Bridgewater, MA 02325**

*The purpose of this form is to determine your health history and any special medical needs you may have when you travel on this program. Information provided will be treated confidentially. Any information considered important and essential will be forwarded to your BSC leader for the purpose of serving you as promptly and correctly as possible should you require medical services while abroad.*

Name: \_\_\_\_\_

Travel Destination: \_\_\_\_\_

Are you generally in good physical condition? Yes/No    If no, please explain. \_\_\_\_\_

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Are you currently being treated for any medical condition? Yes/No    If yes, please explain. \_\_\_\_\_

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Are you a diabetic? Yes/No

Have you ever had epilepsy or other seizure disorders? Yes/No

Do you have asthma? Yes/No

Do you have a heart condition? Yes/No

Do you have or have you had any eating disorders? Yes/No

Have you ever been treated for an emotional disorder? Yes/No

What diseases have you had in the past 5 years, if any? \_\_\_\_\_

Do you have any allergies to foods, medications, insects, environmental factors, etc? Yes/No

If yes, please describe \_\_\_\_\_

Are you taking any medication? Yes/No    If yes, please describe \_\_\_\_\_

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Are you on a restricted diet? (vegetarian?) Yes/No    If yes, please describe \_\_\_\_\_

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Do you anticipate needing any health care or counseling while abroad? Yes/No    If yes, please describe \_\_\_\_\_

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If there is any additional health information that would be helpful for the BSC leader to be aware of during your travel, please describe below.

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