

Health Information Form

U.S.-Philippines Research Experience for Undergraduates (REU)
Department of Biological Sciences
Old Dominion University

Confidential Health Information Form

Participant's Name _____

Date of Birth _____ (mm/dd/yy) Height _____ Weight _____

Health Insurance: All Program participants are required to carry health insurance that covers injury or illness while traveling outside of the United States. See Health Insurance and Consent-to-Treat Form for details.

Do you have or have you had any disease or condition requiring medication, regular physician's care, surgery or other treatment? If yes, please list:

Do you take any medication(s) on a regular, on-going basis? If yes, please list:

Have you ever sought professional help for a psychiatric or emotional problem? If yes, please explain:

Do you have any of the following? If yes, please explain type and severity:

Medication Allergies	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Food Allergies	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Other Allergies	<input type="checkbox"/> NO	<input type="checkbox"/> YES	_____
Asthma	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Require epinephrine or hospital? _____
Diabetes	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Require insulin? _____
Epilepsy	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Explain: _____

Do you have any other health condition that may need to be considered? If yes, explain:

I understand that submission of inaccurate and/or incomplete information about medical and psychiatric health history may result in dismissal from the program. Yes No

Participant's Signature _____

Date _____

Physician's Statement (to accompany participant's health information form)

Participant's Name _____

Participant's Address _____

Attention Physician: Your patient is requesting a health evaluation to participate in a research program in the Philippines this summer. The experience requires a moderate level of physical activity and presents moderate degree of emotional challenge. Participants must be able to function somewhat independently during the 8-week duration. Environmental and other conditions the participant may face include, but are not limited to, the following: tropical heat and sun, and travel within a dengue-endemic region.

I examined _____ on _____, 201__.

Listed below are my patient's abnormal findings:

My patient is taking the following medication(s): _____

Medication allergies: _____

Chronic medical conditions: _____

History of psychiatric or emotional problem(s)? NO YES If yes, please explain:

Immunization Record:	Primary Series Date(s)	Booster Date(s)
DPT	_____	_____
Tetanus	_____	_____
MMR	_____	_____
Hepatitis A (suggested)	_____	_____
Hepatitis B (suggested)	_____	_____

In my judgment, the following physical or mental conditions are of potential concern for full and successful participation in the Program:

In my opinion, _____ is **or** is NOT capable of participating in the described program.

Physician's Signature: _____ Date _____

Physician's Name (please print) _____

Street Address _____

City _____ State _____ ZIP _____ Phone _____

Note: The Old Dominion University medical officer reviews these records. Copies are retained by the on-site coordinator in the Philippines for the duration of the Program.