Sample Health Information Form

U.S.-[FOREIGN SITE] Research Experience for Undergraduates (REU)
Department of ABC
XYZ 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 NO YES ______________________________

Food Allergies NO YES ______________________________

Other Allergies NO YES ______________________________

Asthma NO YES Require epinephrine or hospital? __________

Diabetes NO YES Require insulin? ______________________

Epilepsy NO 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 [LABORATORY/FIELD] research program in [FOREIGN SITE] this summer. The experience requires [LEVEL OF PHYSICAL ACTIVITY] and presents [DEGREE OF EMOTIONAL CHALLENGE]. Participants must be able to function relatively independently during the [LENGTH OF TIME] duration. Environmental and other conditions the participant may face include, but are not limited to, the following: [LIST].

I examined ______________________ on ____________, 200__.

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 ____________

Phsycian's Name (please print) ______________________

Street Address ______________________

City ______________________ State ________ ZIP __________

Phone ______________________

Note: The XYZ University medical officer reviews these records. Copies are retained by the on-site coordinator in [FOREIGN SITE] for the duration of the Program.

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