AUSM

Autonomous University of Social Movements

A project of the Mexico US Solidarity Network

(773) 583 - 7728
ausm@mexicosolidarity.org
www.mexicosolidarity.org

Study Abroad Medical Form

The medical form must be completed by applicants and returned to the Autonomous University of Social Movements (AUSM) as an integral part of the confirmation procedure for participation in the Study Abroad Program. Part I of the form is completed by the participant and Part II of the form is completed by the participant's physician based on a complete medical exam conducted within the past twelve months.

Part I

Name: ____

Gender: ____

Birth date: ______________________________________

Dates of study abroad program: ______________________

Address: ____

City, state, zip: __________________________________

Telephone: ______________________________________

Other phone: ____________________________________

Has your physical activity been restricted for any reason during the past five years?

____

Have you consulted or been treated by a clinic, physician, or other medical practitioner during the past five years other than routine check-ups? If yes, please explain.

____

Have you been hospitalized during the past five years? If yes, please explain and provide dates.

____

3460 W. Lawrence Ave. Chicago, IL 60625

(773) 583 - 7728
ausm@mexicosolidarity.org
www.mexicosolidarity.org

Do you have any chronic or recurrent illness? Any permanent or chronic injury or physical disability? If yes, please explain?

____

Have you had an allergic reaction to prescription or over-the-counter medicines or immunizations? If yes, please explain.

____

Are you currently taking any medications (including oral contraceptives)? If yes, please explain.

____

Do you have any allergies? If yes, please explain.

____

Do you have any health requirements or dietary restrictions based on religion? If yes, please explain.

____

Do you have any habits that may adversely affect your health? If yes, please explain.

____

Are you currently or have you ever been under the care of a psychiatrist or psychologist? If yes, please explain.

____

Do you have any pre-existing medical conditions not covered in the above questions? If yes, please explain.

____

AUSM

Autonomous University of Social Movements

A project of the Mexico US Solidarity Network

(773) 583 - 7728
ausm@mexicosolidarity.org
www.mexicosolidarity.org

Emergency contact information

Name: ____________________________________

Telephone: ______________ Email: ______________________

Relationship to applicant: _________________________________

Authorization to release medical records and permission for emergency medical treatment:

Please complete and sign the following.
As an applicant to an Autonomous University of Social Movements Study Abroad Program,

I, _______________________________hereby authorize the physician or other medical provider completing Part II of this Medical Form, together with any other physician or medical provider who has provided information to the Autonomous University of Social Movements in connection with my application or participation in the Program, to release any or all medical records or information pertaining to me to the Autonomous University of Social Movements. I also authorize the release by the Autonomous University of Social Movements of my medical records or other medical information pertaining to me, to my parent or other designated contact person in the event of an emergency. On rare occasions, an emergency requiring treatment in a hospital and/or surgery may develop. In most cases, administration of an anesthetic, treatment of an injury or operation upon an individual cannot be done without consent of the patient. In order to prevent a dangerous delay in an emergency situation where the Autonomous University of Social Movements is either unable to contact my parent of guardian to give you my consent, I hereby authorize the Autonomous University of Social Movements's representative to secure whatever medical treatment is deemed necessary, including administration of an anesthetic and surgery. I hereby verify that all of the information contained in this form is accurate and complete and acknowledge that any failure to provide accurate and complete information, including notification to the Autonomous University of Social Movements of any changes in my health affecting the accuracy or completeness of the information contained in this form, may result in my dismissal from the program. I agree to notify the Autonomous University of Social Movements of any material changes in my health that occur prior to the start date of the program.

Signature of applicant

X ____ Date: ___________________

Printed name: ______________________________________

Program dates: _____________________________________

3460 W. Lawrence Ave. Chicago, IL 60625

AUSM

Autonomous University of Social Movements

A project of the Mexico US Solidarity Network

(773) 583 - 7728
ausm@mexicosolidarity.org
www.mexicosolidarity.org

Part II

To the examining physician: The Autonomous University of Social Movements Study Abroad Program will take the participant to both urban and rural areas of Cuba.

Participants must be in reasonable physical shape and be able to walk several kilometers occasionally in hilly terrain. Living conditions and food will probably be different than those to which the applicant is accustomed. Please carefully consider the applicant's general fitness and physical and mental health in relation to the stresses inherent in a 13-week study abroad program in Cuba.

Does the applicant exhibit any health problems? If yes, please explain.

____

Is the applicant seriously underweight or overweight? If yes, please explain.

____

Does the applicant have any allergies? If yes, please explain.

____

Is the applicant currently under medical treatment or taking medications? If yes, please explain.

____

Is there any history of behavioral disorders or emotional disturbances, such as sever mood swings? If yes, please explain.

____

Has the applicant ever been under psychiatric treatment? If yes, please explain.

____

Are there any congenital malformations or chronic conditions that may require additional treatment? If yes, please explain.

____

Would strenuous physical activity, such as carrying luggage or walking long distances, cause the applicant hardship?

____

3460 W. Lawrence Ave. Chicago, IL 60625

AUSM

Autonomous University of Social Movements

A project of the Mexico US Solidarity Network

(773) 583 - 7728
ausm@mexicosolidarity.org
www.mexicosolidarity.org

Do you have any further recommendations or instructions regarding the care of this patient?

Having examined this applicant and reviewed his or her past medical history,

I ________________________________, consider that ________________________________
(printed name of physician) (printed name of applicant)
is fit to participate in a program with the Autonomous University of Social Movements Study Abroad Program in Cuba during the Fall/Spring/Summer of 20____. Having received permission from said applicant, I would be willing, if indicated, to discuss issues pertaining to this applicant's health status with the professional staff of the Autonomous University of Social Movements and will furnish pertinent medical records upon request.

Signature of physician: ______________________________________ Date: ______________

Address City, state, zip: ____

Telephone: ______________________________ Fax: _____________________________

Email: ____

3460 W. Lawrence Ave. Chicago, IL 60625