Office of Study Abroad and Outreach Medical Report

Instructions

INSTRUCTIONS TO THE STUDENT: As part of your participation in this program, you are required to have a medical screening and to obtain clearance from Beu Health Center or another health care provider. **(Note: if you are obtaining clearance from a provider other than Beu, complete the "Authorization to Release Medical Information" on the next page. Please be sure to initial where indicated under the word "REQUIRED" and sign and date the form).** Then complete Part I and review it with your health care provider. Your health care provider must complete Part II and mail parts I and II to Beu Health Center, Attn: Triage Nurse

NOTE: It is our policy not to accept reports completed by parent-physicians/health care providers. The health care provider completing this form should be a licensed physician, nurse practitioner or physician's assistant.

To be completed by the Office of Study Abroad and Outreach:
Name and location of study abroad program or course: _____

Special medical/health considerations inherent in the location or program design include the following:

_____

_____

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: You are requested to evaluate the physical health of the student planning to participate in this study abroad program. The pressures of living and studying in an unfamiliar environment are considerable. In addition, the nature of these programs is such that participants are often engaged in numerous scheduled activities (traveling, site visits, lectures, etc.) throughout the day and maintain this rigorous schedule for many days at a time. It is extremely important that all participants be able to adjust to dramatic changes in climate, level of physicality, and living conditions. Operating in a group setting can also create emotional and physical stress for those not able to meet the demands of living in a new and different environment. In some cases, mild physical disorders can become serious under the stress of a rigorous schedule, and become especially challenging in an unfamiliar location.

A student will not be rejected due to a physical condition unless it is of such a nature as to prevent successful participation in the required elements of the program. Information regarding the participant's health, however, will be invaluable to staff in anticipating and dealing with any health problems that may arise during the program.

It is essential that your assessment be based on a current and thorough physical examination and knowledge of the student's medical history.

Parts I and II – Do not give to the student;

Mail to Beu Health Center, Attn: Triage Nurse, Western Illinois University, 1 University Circle, Macomb, IL 61455, or fax to (309) 298-2188 (please note that fax transmission should be verified to ensure it was successful).

*****If student is not being examined by Beu Health Center, please include an official business card or letterhead from the health care provider's office, with contact information.**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Beu Health Center
1 University Circle, WIU
Macomb, IL 61455
Phone (309) 298-1888
FAX (309) 298-2188

Student: Fill out this box, initial and sign where appropriate below. PATIENT NAME (Please print):

Last Name	*First Name*	*MI*	*Date of Birth*

Address	

9-digit WIU Student ID #	*Local Phone*

RELEASE FROM:

☐ Beu Health Center

☐ Name: _____

Address	*City*	
State	*Zip*	*FAX*

RELEASE TO:

X Beu Health Center

X Triage Nurse

Address	*City*	
1 University Circle	Macomb	
State	*Zip*	*FAX*
IL	*61455*	*(309) 298-2188*

PURPOSE:

☐ Patient's Request ☐ Continuing Treatment
☐ Legal ☐ Insurance X Other : participation in study abroad

DATES OF RECORDS TO BE RELEASED:

Date of study abroad exam and any prior records the health care provider deems relevant

SPECIFY RECORDS TO BE RELEASED:

☐ Allergy Records ☐ X-ray report ☐ X-ray CD ☐ Physical Exam ☐ Laboratory Results ☐ Immunization records

☐ TB tests ☐ Clinic Notes X Other (Specify): Parts I and II of the "Office of Study Abroad and Outreach Medical Report Form"

☐ Entire Health Record ($20.00 Charge applies). There is no charge to mail health record to another healthcare professional (e.g. physician). Entire health record will not be faxed.

REQUIRED: By <u>initialing</u> the boxes below, I am authorizing the release of the following information:

_____ Alcohol and/or drug abuse treatment information (as protected under 42 CFR)
_____ HIV/AIDS Information (as defined by Illinois Statute)
_____ Mental Health Records (as defined by the Illinois Mental Health and Developmental Disabilities Confidentiality Act)

This consent will terminate upon (specific date, event or condition): the date of my return from my study abroad program. I understand that I may revoke this consent at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer. **<u>If no calendar date is specified above, Mental Health Records may only be released on the date this release is received by our office.</u>**

NOTICE TO PATIENT:

I fully understand that my medical record and health information for the above date(s) may contain alcohol/drug abuse, and/or HIV/AIDS test results, mental health information and/or other information.* I understand that any of the above selected records may contain medical information from outside sources and authorize Beu Health Center to release these records and health information if necessary for the continuity of care or if I have requested my complete record. I understand that I have the right to inspect and/or obtain a copy (for the appropriate fee) of my medical record prior to disclosure. I understand that this consent applies both to written and verbal release of information. I absolve, discharge, release, & hold harmless the Board of Trustees for Western Illinois University together with its agents and employee for any legal liability, claims, or damages which may arise from the disclosure of this information.

*** To receiving agency: these records may not be re-disclosed without the patient's consent.**

_____ _____
Signature of patient or authorized legal guardian *Date*

_____ _____
Relationship to patient, if signed by authorized representative *Date*

_____ _____
Witness signature (required for mental health/HIV/substance abuse) *Date*

PART I: Screening examination

(To be completed by the student, verified by the health care provider, and sent to Beu Health Center, Attn: Triage Nurse)

A standard medical screening should be documented in Beu Health Center and the health care provider's official medical records only, and together with any medical reports submitted from outside consultants, is subject to the standard policies governing release of confidential health data. This form should be completed and submitted to the health care provider prior to the examination. THIS FORM SHOULD BE RETURNED TO BEU HEALTH CENTER, ATTN: TRIAGE NURSE, AND NOT TO THE OFFICE OF STUDY ABROAD AND OUTREACH.

(To be completed by the student and verified by health care provider)

Please check conditions you now have or have had in the past.

	Alcohol Abuse		Epilepsy		Mononucleosis	Surgery (specify):
	Allergy symptoms		Hay Fever		Organ Transplant	
	Arthritis		Headaches		Pneumonia	
	Asthma		Hearing Problems		Pregnancy	
	Back Problems/Injury		Heart Murmur (explain medication needs if indicated)		Rheumatic Fever	Fractures (specify):
	Bladder Problems				Seizure Disorder	
	Bowel Problems		Heart Problems		Sinus Problems	
	Bronchitis		Hepatitis		Skin Problems	
	Cancer		Hernia		Substance Abuse	
	Chicken Pox		Hives		Thyroid Disease	
	Concussion		Hypertension		Tonsillitis	
	Depression		Hypotension		Tuberculosis	
	Diabetes		Kidney Problems		Ulcers	Other (specify):
	Ear, Nose, Throat Problems		Meningitis		Vertigo or Dizziness	
	Eating Disorder		Menstrual Problems		Visual Disturbances	
	Eczema		Migraine Headaches		Whooping Cough	

Comments related to any of those marked above:

A. Do you have an illness or condition not previously listed for which you are now being treated?
If YES, please specify:

B. Please list any treatments and dates of treatment received at a hospital (emergency room, etc.):

C. Have you had symptoms and/or treatments for anxiety, depression, bipolar disorder, or any other emotional or psychological problems?
Describe and list current medications:

For students being screened at Beu Health Center:
Please attach any additional information that your family health care provider would like to share concerning treatments received.

PART II: Medical assessment

(To be completed by the health care provider and sent to Beu Health Center, Attn: Triage Nurse. Beu Health Center: please scan entire form into patient's health records and send pages 5 and 6 to the Office of Study Abroad and Outreach).

Please note that this disclosure will be retained in the student's file in the Office of Study Abroad and Outreach and shared with faculty directors and personnel of institutions abroad or affiliate providers. The information on this form is subject to the Family Educational Rights and Privacy Act of 1974 (FERPA).

Student's Name:_____DOB_____ ID Number_____

1. Have you reviewed Part I "Medical Screening" with the student? ☐ Yes ☐ No
2. Have you conducted a standard physical examination of the student? ☐ Yes ☐ No
3. To the best of your knowledge, based on your examination and the information provided by the student, is this student physically and mentally able to participate in the described program? ☐ Yes ☐ No
4. Are further medical consultations recommended before this student participates on this study abroad program? ☐ Yes ☐ No
5. To your knowledge, are there any predisposing medical or surgical factors that may under stress or duress during the program represent a need for immediate therapy? ☐ Yes ☐ No

If the answer to question 3 is "No", but you would like to conditionally clear the student for participation, please elaborate in the space provided below, or further explain on a separate, signed note that is printed on the health care provider's office or clinic letterhead. Do not elaborate if the student is not cleared for participation.

_____

_____

_____

_____

_____

CONCLUDING ASSESSMENT: *Based upon the information provided to me by the student and pursuant to an assessment of the student's health condition as determined in PART I—Screening Examination and PART II—Medical Assessment, I find:*

☐ There are NO medical contraindications to participation, and the student is cleared to participate in this program.

☐ The student is CONDITIONALLY cleared to participate. This conditional clearance is contingent upon the student arranging for the following but only if there is concurrence from the Office of Study Abroad and Outreach that such arrangements are suitable for the type of program in which the student plans to participate:

☐ Further medical consultation as recommended in Question 4 of Part II—Medical Assessment.
☐ Other arrangements must include:

_____

_____

_____

☐ There are MEDICAL contraindications to participation and in my judgment the student is NOT cleared to participate.

_____

HEALTH CARE PROVIDER NAME (Please print) HEALTH CARE PROVIDER SIGNATURE DATE

_____

ADDRESS ZIP CODE TELEPHONE NUMBER

PLEASE ATTACH AN OFFICIAL BUSINESS CARD OR LETTERHEAD OF THE HEALTH CARE PROVIDER, WITH NAME AND CONTACT INFORMATION