

Please complete the information below. Participation in the travel/study program is contingent upon the Office of International Programs receiving a completed medical form, among other documents. Your healthcare provider should complete this form based on an examination within six months of the program departure date. **Please upload this form to your online Wofford Travel/Study application by November 4th.**

STUDENT'S NAME _____
Last First Middle

ADDRESS _____

W NUMBER _____ DATE OF BIRTH _____ AGE _____

PARENT/GUARDIAN _____
Name Relationship to Student

TELEPHONE Home (____) ____ - ____ Work (____) ____ - ____ Cell Phone (____) ____ - ____

Please mark the program in which you are enrolled:

| X | Program (Leaders) | Potential Activities |
|----------|---|---|
| | Argentina and Chile: Geographic Diversity, Cultural Longevity, and Economic Change (Olsen/Terrell) | Canoeing/Kayaking, Walking, Hiking |
| | Dialogue with China: Its Past, Present, and Future (Efurd/Zhang) | Cycling, Walking |
| | Egypt: Temples, Tombs, and Ancient Egyptian Religion (Lilly/Tomkins) | Walking |
| | Evolution in Action: The Natural History of the Galapagos Islands (Carroll/Cruze) | Paddleboarding, Walking, Hiking, Cycling, Canoeing/Kayaking, Swimming, Snorkeling |
| | Exploring South Africa: A Nation of Resilience, Grace, and Beauty (Gonzalez/Stanton) | Hiking, Walking |
| | Friluftsliv & Frozen Fjords: A Wintery Expedition into Norwegian Happiness & Well-Being (Brown/McQuiston) | Walking, Hiking, Canoeing/Kayaking, Swimming |
| | Germany: A Journey Through Time (Stefanic Brown) | Cycling, Walking |
| | Global Art Experience: Ghana (Forstater/Scott-Felder) | Hiking, Walking |
| | Little Cayman SCUBA Adventure (Mitchell/Morris) | SCUBA Diving, Walking, Swimming, Snorkeling |
| | More Than a Selfie: Cultural Immersion in the Heart of Morocco (Newman/Sandifer) | Walking, Hiking |
| | New Zealand: Environment, Culture, & Film in the Land of the Long White Cloud (Robinson/Swicegood) | Walking, Hiking, Swimming |
| | Nicaragua: Yoga and the Tropical Environment (Bradham/Valde) | Walking, Hiking, Swimming, Snorkeling, Surfing, Yoga |
| | Page to Stage: A Literary Journey in the British Isles (Hall/Ware) | Walking |
| | Royal Scandal! Misadventures in British History (Cathey/Jones) | Walking |
| | Visionary Spain: Art, Social Movements, and Imagined Utopias in Three Cities (Lackey/Young) | Cycling, Walking |
| | World War II and Its Aftermath (Bostic/Harris) | Hiking, Walking |

PERSONAL MEDICAL HISTORY OF STUDENT

To be completed by/with a Healthcare Provider (this can include Wofford College Health Services staff)

ALLERGIES:

Drug Allergies: _____ Food Allergies: _____

Medications or injections for the above allergies: _____

***HEALTH HISTORY:** Place a checkmark in the appropriate box if the patient has any of the following conditions:

| | | | | | | | |
|--------------------------|--------------------------------|--------------------------|----------------------------|--------------------------|-------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | Eye Injury/Disease | <input type="checkbox"/> | Migraine Headaches | <input type="checkbox"/> | Sexually Transmitted Disease |
| <input type="checkbox"/> | Asthma | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | Mononucleosis | <input type="checkbox"/> | Skin Problems |
| <input type="checkbox"/> | Back Problems | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | Neurological Disorder | <input type="checkbox"/> | Thyroid Problem |
| <input type="checkbox"/> | Blood Disorder/Anemia | <input type="checkbox"/> | Hepatitis (Jaundice) | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | Ulcer/Stomach or Duodenal |
| <input type="checkbox"/> | Bone/Joint Problem | <input type="checkbox"/> | Hernia | <input type="checkbox"/> | Recurrent Bronchitis | <input type="checkbox"/> | Urinary Tract Infections |
| <input type="checkbox"/> | Cardiac Problem | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Recurrent Sinusitis | <input type="checkbox"/> | Other: |
| <input type="checkbox"/> | Chest Pain/Shortness of Breath | <input type="checkbox"/> | Inflammatory Bowel Disease | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | |
| <input type="checkbox"/> | Chicken Pox | <input type="checkbox"/> | Kidney Stone/Disease | <input type="checkbox"/> | Seizures/Epilepsy | <input type="checkbox"/> | |
| <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Malaria | <input type="checkbox"/> | Severe Menstrual Cramps | <input type="checkbox"/> | |

PLEASE PROVIDE DETAILS OF ALL THE CONDITIONS CHECKED ABOVE: _____

Hospitalizations, treatments, surgeries (including outpatient), or procedures (include dates and doctors): _____

Healthcare Provider for above conditions (if differs from provider completing form): _____

Address: _____

Phone: _____ Fax: _____

Is the student currently on a restricted diet? Please explain, and mention vegetarianism if applicable. _____

All Wofford College students are required to have had the following immunizations before enrolling as new students: COVID-19, MMR x2, Tetanus-Diphtheria, Polio, Tuberculosis Screening, and Hepatitis B series. **Please list any additional immunizations required or recommended for the student's overseas destination, if applicable.** Please indicate below if your office has administered these and the date.

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

SPECIAL ACCOMMODATIONS:

Does the student have any speech, hearing, or eyesight impairment that might affect participation in the program? _____

Does the student have any physical disability that might cause hardship through change of diet, carrying luggage, or strenuous travel? _____

Does the student have any learning disabilities? If so, are special accommodations required? _____

MENTAL HEALTH HISTORY: Place a checkmark in the appropriate box if the patient has any of the following conditions:

| | | |
|---|---|---|
| <input type="checkbox"/> Anxiety/Panic Attacks | <input type="checkbox"/> Drug and/or Alcohol Dependency | <input type="checkbox"/> Severe sleep disorders |
| <input type="checkbox"/> Behavioral Disorders | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Unusual degrees of anxiety, fear, or guilt |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Difficulty with authority figures or peers | <input type="checkbox"/> Phobias | |

PLEASE PROVIDE DETAILS OF ALL THE CONDITIONS CHECKED ABOVE (attach additional pages as necessary):

Medications: Past: _____ Current: _____

For the examining physician: To your knowledge, are there any predisposing medical, surgical, or emotional factors that may, under stress during the program, present a need for immediate therapy while off-campus? Please explain (attach additional pages as necessary).

How long have you known the student? _____ Date of the student's most recent examination: ____/____/____

What is the student's general state of health? _____ Excellent _____ Good _____ Fair _____ Poor

What is the student's general state of mental health? _____ Excellent _____ Good _____ Fair _____ Poor

I believe _____ to be physically and emotionally able to participate in the off-campus travel/study program indicated above.
Name of Student

Completed by:

Provider's name: _____ Signature: _____

Address: _____

Tel: _____ Fax: _____