



MEXICAN SOCIAL MOVEMENTS • STUDY ABROAD PROGRAM

Mexico Solidarity Network and UAM-Xochimilco partnering for a better world

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.



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Have you ever had a serious or acute illness? If yes, please explain.

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.



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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 or 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: _____



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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 Mexico. 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 Mexico.

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?

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?



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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 Mexico 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: _____