

NYU IN FLORENCE

Study Abroad Physical Exam, Consent, and Release Form (Page 1 of 8)

Name	University ID Number
NYU in Florence	
NYU Site Abroad	Semester/Year

In submission of this form, I acknowledge that New York University has no obligation to seek any medical treatment whatsoever on my behalf.

Personal Information

		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth: Month/Day/Year ()	Place of Birth		
Local Telephone	School		
Local Address	Apt.		
City	State	Zip Code	Country

Family Information

()			
Father	Telephone ()	E-mail	
Mother	Telephone	E-mail	
Permanent Address	Apt.		
City	State	Zip Code	Country

Emergency Contact Information

Name of Person to Contact in an Emergency			
Relationship to Student			
Address			Apt.
City ()	State ()	Zip Code	Country
Telephone ()	Mobile Telephone		
Work Telephone	E-mail		

Return this form to NYU Study Abroad Admissions

Name

University ID Number

NYU in Florence

NYU Site Abroad

Semester/Year

To the Parents or Legal Guardian:

If your son, daughter, or ward will be under the age of 18 years while on a New York University Study Abroad Program, it is our policy to secure your consent for medical treatment. By signing the consent form below, you will be giving your consent for any medical evaluation and treatment necessary to ensure the continued health of the student. In the event of a major health problem, whenever possible, specific permission will be obtained from you.

Authorization for Treatment of a Minor

I, _____, being parent or legal guardian of _____, give my consent to New York University Study Abroad, the physicians and other personnel utilized abroad, to administer such care, procedures, and treatment that is deemed necessary and in the best interest of the patient. As long as the medical or surgical treatment considered necessary in the situation is in accordance with the generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, so state): _____.

I understand that this authorization is good until the time at which the minor mentioned above reaches his or her 18th birthday. In submission of this form, I acknowledge that New York University has no obligation to seek any medical treatment whatsoever on behalf of my child.

Signature (parent or guardian)

Date

Address

()

City

Home Telephone

()

State

Zip Code

Work Telephone

Name

University ID Number

NYU in Florence

NYU Site Abroad

Semester/Year

Medical History | To be completed by physician

Please check any of the conditions listed below that the patient has had or currently has.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> German measles (rubella) | <input type="checkbox"/> Trouble seeing | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Gallbladder problems |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Trouble hearing | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Migraines | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Tension headaches |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Vaginal infection | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bruising problems | <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Back trouble | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Breast lumps/tumors | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Uterine tumor | <input type="checkbox"/> Uterine cyst | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Discharge from penis | <input type="checkbox"/> Discomfort when urinating | <input type="checkbox"/> Lumps or lesions on genitals | |
| <input type="checkbox"/> Pain in the genitals | <input type="checkbox"/> Other problems: _____ | | |

Does the patient have any disabilities? No Yes

Students with disabilities who will be studying abroad should contact the Henry and Lucy Moses Center for Students with Disabilities (212.998.4980 voice and TTY) in order to discuss resources that might be required, to provide the necessary documentation, and to arrange for these services well before departure.

Has the patient ever had surgery? No Yes — If yes, please provide details:

Has the patient ever been hospitalized? No Yes — If yes, please provide details:

Has the patient been treated for an emotional or psychiatric condition? No Yes — If yes, please provide details:

Students who are currently being treated for such a condition should speak with their mental health professional regarding their time abroad, including arranging for services during their time abroad prior to departure, as well as providing for any required medication. The Office of Global Education (212.992.9940) can provide assistance with referrals abroad.

Date of the patient's last

Dental Examination

Eye Examination

Physical Examination

Gynecological Examination

Return this form to NYU Study Abroad Admissions

Name

University ID Number

NYU in Florence

NYU Site Abroad

Semester/Year

Medications/Allergies

Is the patient currently taking any medications, vitamins, over-the-counter medications, or other health supplements?

If so, please list:

Is the patient allergic to any medications?

No Yes — If yes, please provide details:

Is the patient allergic to any food or other items (e.g., bee stings, peanuts)?

No Yes — If yes, please provide details:

Other allergies?

No Yes — If yes, please provide details:

Social History

Does the patient smoke now?

No Yes — How many packs per day? ____ x ____ Years

Has the patient smoked in the past?

No Yes — How many packs per day? ____ x ____ Years

Does the patient consume alcohol?

No Yes

Has the patient consumed alcohol in the past?

No Yes

Nutrition

Does the patient follow a special diet?

No Yes — If yes, please provide details:

Has the patient ever experienced a medically significant amount of weight change in a year?

No Yes — If yes, please provide details:

Family History

To be filled out by student in conjunction with physician. Please check any of the following medical conditions that anyone in the patient's family has or has had in the past. Please include relationship to patient.

Diabetes: _____ High cholesterol: _____ Hypertension: _____

Heart disease: _____ Sudden death: _____ Cancer: _____

Stroke: _____ Kidney disease: _____ Gastrointestinal disease: _____

Birth defect or hereditary disease: _____ Other: _____

Return this form to NYU Study Abroad Admissions

Name

University ID Number

NYU in Florence

NYU Site Abroad

Semester/Year

Immunization

Please indicate which of the following immunizations the patient has received and the date.

To be in compliance, students must have both items in section A **or** one each from sections B, C, and D.

A. M.M.R. (measles, mumps, rubella) if given instead of individual immunization.

Month/Day/Year

First dose: immunized on or after first birthday **and** on or after January 1, 1972.

___/___/___

Second dose: immunized 15 months after birth or later **and** at least 28 days after first dose.

___/___/___

B. MEASLES (rubeola)

Had the disease, confirmed by office record.

___/___/___

Has report of adequate immune titer—MUST SUBMIT COPY OF LAB REPORT.

___/___/___

First dose: immunized on or after first birthday **and** on or after January 1, 1968; **and** second dose: immunized 15 months after birth or later **and** at least 28 days after first dose.

___/___/___
___/___/___

C. MUMPS

Had the disease, confirmed by office record.

___/___/___

Has report of adequate immune titer—MUST SUBMIT COPY OF LAB REPORT.

___/___/___

Immunized on or after first birthday **and** on or after January 1, 1969.

___/___/___

D. RUBELLA (German measles)

Has report of adequate immune titer—MUST SUBMIT COPY OF LAB REPORT.

___/___/___

Immunized on or after first birthday **and** on or after January 1, 1969.

___/___/___

E. MENINGOCOCCAL MENINGITIS

To be filled out by student in conjunction with physician. Check one box.

I have (for students under the age of 18: My child has):

had the meningococcal immunization (Menomune™) within the past 10 years.

Date received: ___/___/___

read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal meningitis within 30 days from my health care provider or New York University's Student Health Center, Allergy and Immunology Services.

read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signature (Student/Parent or Guardian)

Month/Day/Year

All students attending NYU Study Abroad, including visiting students, are required to meet New York State laws regarding immunizations and to ensure that the NYU Student Health Center has this information on file. Failure to do so will impede release of grades, financial aid, etc.

F. OTHER IMMUNIZATIONS

Tetanus ___/___/___

Hepatitis A ___/___/___

Flu vaccine ___/___/___

Hepatitis B ___/___/___

Yellow fever ___/___/___

Pneumonia vaccine ___/___/___

Polio ___/___/___

Rabies ___/___/___

Typhoid ___/___/___

Other, please list type and date:

_____ ___/___/___

Return this form to NYU Study Abroad Admissions

Name

University ID Number

NYU in Florence

NYU Site Abroad

Semester/Year

Review of Systems

Check any of the conditions listed below that the patient has or has had in the past.

Please provide details as necessary.

CONSTITUTIONAL SYMPTOMS No Yes
(e.g., headaches, fatigue, fever)

MUSCULOSKELETAL No Yes
(e.g., joint pain/weakness, cold extremities, difficulty walking)

EYES No Yes
(e.g., eye disease/injury, blurred or double vision)

INTEGUMENTARY (SKIN) No Yes
(e.g., rash; change in skin color, hair, or nails)

EARS/NOSE/MOUTH/THROAT No Yes
(e.g., hearing loss/ringing, drainage, chronic sinus problems, bleeds, swollen glands)

BREAST DISEASE No Yes
(e.g., abnormal mammogram, pain, lump, discharge)

CARDIOVASCULAR No Yes
(e.g., heart issues, chest pain, angina)

NEUROLOGICAL No Yes
(e.g., headaches, convulsions, seizures, paralysis, head injury)

RESPIRATORY No Yes
(e.g., chronic/frequent cough, blood)

PSYCHIATRIC No Yes
(e.g., depression, insomnia, fainting, memory loss/confusion)

GASTROINTESTINAL No Yes
(e.g., frequent diarrhea, constipation, blood in stool, nausea, vomiting)

ENDOCRINE No Yes
(e.g., excessive thirst/urination, hormonal problems, temperature intolerance)

GENITOURINARY No Yes
(e.g., painful urination, blood in urine, burning on urination, kidney stones)

HEMATOLOGIC/LYMPHATIC No Yes
(e.g., slow to heal after cuts, anemia, phlebitis, bleeding or bruising tendency, past transfusion)

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other reaction to

- Penicillin or other antibiotics No Yes
- Morphine, Demerol, or narcotics No Yes
- Novocain or anesthesia No Yes
- Aspirin or pain remedies No Yes
- Tetanus or similar vaccines No Yes
- Iodine, Merthiolate, or antiseptics No Yes

Other drugs/medications: _____

Return this form to NYU Study Abroad Admissions

Name

University ID Number

NYU in Florence

NYU Site Abroad

Semester/Year

Please indicate the last date each item was examined, inclusive of this physical if conducting a new one, and indicate any abnormal issues.

Enter N.E. if not evaluated.	Date	Normal	Abnormal	NOTE: Describe every abnormality in detail. Enter pertinent item number before each comment.
1. Head, face, neck, scalp				
2. Nose, sinuses				
3. Mouth, teeth, throat				
4. Ears (including whispered voice test)				
5. Eyes, pupils, muscles balance				
6. Ophthalmoscopic				
7. Neck and thyroid				
8. Thorax, breasts				
9. Lungs				
10. Heart (murmur, etc.)				
11. Abdomen (including hernial)				
12. Anus and rectum				
13. Endocrine system				
14. GU system				
15. Upper extremities				
16. Lower extremities				
17. Feet				
18. Spine, other musculoskeletal				
19. Neurologic				
20. Psychiatric evaluation				
21. Skin				
22. Lymphatic system				
23. Vascular system (varicosities, etc.)				
24. Other				

Physical Examination Summary

Blood Pressure: _____ Pulse: _____ Height: _____ Weight: _____ Blood Type: _____

Vision: Corrected Uncorrected

OD 20/_____ 20/_____

OS 20/_____ 20/_____

Name

University ID Number

NYU in Florence

NYU Site Abroad

Semester/Year

Based on your evaluation, does this student have a medical or psychiatric condition that could make study in a foreign country, including developing world countries, inadvisable? No Yes — If yes, please provide details:

Please Print

Physician's Name

Physician's Signature

()

Telephone

Date of Examination

Address

City

State

Zip Code