

# NYU IN SHANGHAI

## Study Abroad Physical Examination, Authorization, and Consent Form (Page 1 of 9)

Name

University ID Number

NYU in Shanghai

NYU Site Abroad

Semester/Year

### Authorization for Medical Treatment:

In the event of an accident or illness or other emergency in which I may require immediate medical attention, I authorize NYU in Shanghai to transport me to the emergency medical department of the nearest hospital and to secure medical treatment from an attending or other licensed physician, hospital/clinic, and/or medical provider on my behalf to provide the medical care, tests, procedures, drug, blood and blood products, services, and supplies considered advisable by the physician and other medical staff assessing my medical needs. These services may include pathology, radiology, emergency services (including medical evacuation internal to China as well as externally to another country), and other special services ordered by my attending physician and other medical staff. In consenting to emergency medical treatment, I have not relied on any statements or promises as to the results to be obtained.

In the event that my medical condition requires blood or blood product transfusions, I further authorize any attending or other physicians, hospitals/clinics and their affiliates, and medical providers engaged by NYU in Shanghai on my behalf to administer such transfusions. I understand and acknowledge that NYU in Shanghai or New York University cannot guarantee the safety of the available blood supply according to U.S. standards and that such transfusions may contain hepatitis A, B, and C and HIV.

I further acknowledge that mental health services in China are extremely limited and at times may not be available, and I acknowledge that I am solely responsible for researching and arranging for any mental health services that I may require while I am in China. I further hereby acknowledge that NYU in Shanghai has no obligation to seek any medical treatment whatsoever on my behalf.

**DISCLOSURE OF HEALTH INFORMATION:** While you are studying and living in Shanghai, your health is a top priority to NYU. To obtain the best quality care and quickest response in the event of an emergency, we will release your medical information to local medical services providers. By signing this form, you consent to the release of your physical examination and medical history form to medical services providers in China and you acknowledge that local medical service providers are not bound by the same privacy laws that govern the use of medical information in the United States.

### ACCEPTANCE OF FINANCIAL LIABILITY FOR MEDICAL TREATMENT AND DISPENSED MEDICINE:

In accordance with the above terms and in consideration of the services that may be provided to me, I agree to pay all fees charged by any physician, hospital/clinics, and other medical care provider or entity engaged by NYU in Shanghai to provide medical services for me and for any and all medicine and medical devices provided to me. If the requirements for referral, second opinion, or precertification of care, as outlined by my health insurer, benefit plan, or other payer, have not been followed, I understand that in some instances I may be personally responsible for all charges incurred. I also agree to reimburse NYU in Shanghai and/or New York University for any sum of money that they/it may pay on my behalf for the provision of medical services and treatment or the dispensing of medicine to me.

Student Name

Signature

Date

**If you are under 18 at the time you complete this form, you must contact the Office of Global Programs to obtain parental release forms.**

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**Personal Information**

				<input type="checkbox"/> Male	<input type="checkbox"/> Female
Date of Birth: Month/Day/Year (     )	Place of Birth				
Local Telephone					
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				

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**To the Physician:**

The patient receiving this physical will be studying abroad in Shanghai, China, for approximately four months. Please include any notation of medication and dosages and an investigative report concerning illness that would be relevant to his or her time abroad in addition to the information outlined below from the physical conducted.

**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: _____     |   |   |

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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:

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

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

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*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

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**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

Has the patient been sexually active?  No  Yes

**Nutrition**

Does the patient follow a special diet?  No  Yes — If yes, please provide details: \_\_\_\_\_

Does the patient have any dietary issues that might require monitoring or supplements while living in a developing country?  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: \_\_\_\_\_  Bipolar disorder: \_\_\_\_\_
- Depression: \_\_\_\_\_  Other: \_\_\_\_\_

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**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.

<b>A. M.M.R. (measles, mumps, rubella) if given instead of individual immunization.</b>	Month/Day/Year
<input type="checkbox"/> First dose: immunized on or after first birthday <b>and</b> on or after January 1, 1972.	___/___/___
<input type="checkbox"/> Second dose: immunized 15 months after birth or later <b>and</b> at least 28 days after first dose.	___/___/___
<b>B. MEASLES (rubeola)</b>	
<input type="checkbox"/> Had the disease, confirmed by office record.	___/___/___
<input type="checkbox"/> Has report of adequate immune titer—MUST SUBMIT COPY OF LAB REPORT.	___/___/___
<input type="checkbox"/> First dose: immunized on or after first birthday <b>and</b> on or after January 1, 1968; <b>and</b> second dose: immunized 15 months after birth or later <b>and</b> at least 28 days after first dose.	___/___/___ ___/___/___
<b>C. MUMPS</b>	
<input type="checkbox"/> Had the disease, confirmed by office record.	___/___/___
<input type="checkbox"/> Has report of adequate immune titer—MUST SUBMIT COPY OF LAB REPORT.	___/___/___
<input type="checkbox"/> Immunized on or after first birthday <b>and</b> on or after January 1, 1969.	___/___/___
<b>D. RUBELLA (German measles)</b>	
<input type="checkbox"/> Has report of adequate immune titer—MUST SUBMIT COPY OF LAB REPORT.	___/___/___
<input type="checkbox"/> Immunized on or after first birthday <b>and</b> 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
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New York University recommends that students attending NYU in Shanghai receive all immunizations as recommended by the Centers for Disease Control and the World Health Organization. Please discuss with your health care provider any issues that might arise from declining any of these immunizations.

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**

<input type="checkbox"/> Tetanus	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Flu vaccine	<input type="checkbox"/> Pneumonia vaccine
<input type="checkbox"/> Yellow fever	<input type="checkbox"/> Rabies
<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis (BCG vaccination)
<input type="checkbox"/> Typhoid	<input type="checkbox"/> Other, please list type and date:
<input type="checkbox"/> Hepatitis A	_____

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**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**

- Headaches  No  Yes
- Recent weight change  No  Yes
- Fever  No  Yes
- Fatigue  No  Yes

**MUSCULOSKELETAL**

- Joint pain  No  Yes
- Joint stiffness or swelling  No  Yes
- Weakness of muscles or joints  No  Yes
- Muscle pain or cramps  No  Yes
- Back pain  No  Yes
- Cold extremities  No  Yes
- Difficulty in walking  No  Yes

**EYES**

- Eye disease or injury  No  Yes
- Wear glasses/contact lenses  No  Yes
- Indicate prescription:  
\_\_\_\_\_
- Blurred or double vision  No  Yes

**INTEGUMENTARY (SKIN)**

- Rash or itching  No  Yes
- Varicose veins  No  Yes
- Change in skin color  No  Yes
- Change in hair or nails  No  Yes

**EARS/NOSE/MOUTH/THROAT**

- Hearing loss or ringing  No  Yes
- Earaches or drainage  No  Yes
- Chronic sinus problems  No  Yes
- Nose bleeds  No  Yes
- Mouth sores  No  Yes
- Bleeding gums  No  Yes
- Bad breath or bad taste  No  Yes
- Sore throat or voice change  No  Yes
- Swollen glands in neck  No  Yes

**BREAST DISEASE**

- Prior mammogram  No  Yes
- Breast pain  No  Yes
- Breast lump  No  Yes
- Breast discharge  No  Yes

**NEUROLOGICAL**

- Frequent headaches  No  Yes
- Lightheadedness or dizziness  No  Yes
- Convulsions or seizures  No  Yes
- Numbness or tingling  No  Yes
- Tremors  No  Yes
- Paralysis  No  Yes
- Head Injury  No  Yes

**CARDIOVASCULAR**

- Heart trouble  No  Yes
- Chest pain or angina  No  Yes
- Palpitation  No  Yes
- Shortness of breath  No  Yes
- Swelling of feet/ankles/hands  No  Yes

**PSYCHIATRIC**

- Memory loss  No  Yes
- Confusion  No  Yes
- Nervousness  No  Yes
- Depression  No  Yes
- Insomnia  No  Yes
- Fainting  No  Yes

**RESPIRATORY**

- Chronic or frequent cough  No  Yes
- Spitting up blood  No  Yes
- Shortness of breath  No  Yes
- Wheezing  No  Yes

**GASTROINTESTINAL**

- Abdominal pain  No  Yes
- Loss of appetite  No  Yes
- Change in bowel movements  No  Yes
- Nausea or vomiting  No  Yes
- Frequent diarrhea  No  Yes
- Painful bowel movements  No  Yes

- Constipation  No  Yes
- Rectal bleeding  No  Yes
- Blood in stool  No  Yes

**ENDOCRINE**

- Hormonal problems  No  Yes
- Excessive thirst or urination  No  Yes
- Heat or cold intolerance  No  Yes
- Skin becoming drier  No  Yes
- Change in hat or glove size  No  Yes

**GENITOURINARY**

- Frequent urination  No  Yes
- Burning on urination  No  Yes
- Painful urination  No  Yes
- Blood in urine  No  Yes
- Change in force of urine  No  Yes
- Strain with urination  No  Yes
- Incontinence or dribbling  No  Yes
- Kidney stones  No  Yes

**HEMATOLOGIC/LYMPHATIC**

- Slow to heal after cuts  No  Yes
- Bleeding or bruising tendency  No  Yes
- Anemia  No  Yes
- Phlebitis  No  Yes
- Past transfusion  No  Yes
- Enlarged glands  No  Yes

**ALLERGIC/IMMUNOLOGIC**

- History of skin reaction or other reaction to:
- Penicillin or other antibiotics  No  Yes
- Morphine/Demerol/narcotics  No  Yes
- Novocain or anesthesia  No  Yes
- Aspirin or pain remedies  No  Yes
- Tetanus or similar vaccines  No  Yes
- Iodine/Merthiolate/antiseptics  No  Yes
- Other drugs/medications: \_\_\_\_\_

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**Physical Examination Summary**

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Vision:        Corrected        Uncorrected  
 OD            20/\_\_\_\_\_        20/\_\_\_\_\_  
 OS            20/\_\_\_\_\_        20/\_\_\_\_\_

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

Enter <b>N.E.</b> if not evaluated.	Date	Normal	Abnormal	<b>NOTE:</b> 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				

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

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**Please Print**

Physician's Name ( )	Physician's Signature		
Telephone			
Date of Examination			
Address	City	State	Zip Code