Part VIII - HEALTH REPORT

Please note that it is imperative that you fill out all pages of this form honestly and accurately. Our intention is to learn as much as possible about your physical, emotional and psychological needs so that you can have a successful off-campus experience. If you are accepted to the program, this information will assist us in creating a positive experience for you and in obtaining or providing appropriate care if there is an emergency.

This medical report is subject to review by the St. Lawrence University Health Center staff, Director and Assistant Director of the Sustainability Semester and Medical Reviewer. The Selection Committee will base its decisions on the strength of your application, your interview, your academic standing and your references. They will not view or consider your medical form and any listed physical or emotional condition(s) unless an independent medical reviewer determines:

- it is of such a serious nature or degree as to prevent successful participation in the program;
- medical care for an individual’s medical or psychological challenge is not available in the program area;
- and/or the living and environmental conditions to which the applicant could be exposed would present a serious risk to his/her health and/or the health and safety of others.

In this instance, you will be contacted in order to better assess your potential participation in the program. The Sustainability Semester reserves the right to deny entry into the program if it determines that your condition(s) meet the above listed characteristics.

Should you develop any significant health problems between the time of acceptance into the program and commencement of the off-campus component, it is your responsibility to notify the program director. A medical report should accompany this notification for review by the Director of Health Services.

Please print the forms listed below and send by November 1st to:

SUSTAINABILITY SEMESTER/OUTDOOR STUDIES
ATTN: SHERRIE KELLY
ST. LAWRENCE UNIVERSITY
23 ROMODA DR.
CANTON, NY 13617
Fax: (315) 229-5019

☐ Part 1: Health Report Form
☐ Part 2: Medical Release Form
☐ Part 3: Physician/Counselor Report Form (if applicable)
## Part 1: Health Report Form

For Outdoor Studies Use Only:
- [ ] Medical Screener Review Okay
- [ ] Check Further
- [ ] Secondary Review Okay

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Follow Up Steps Taken:

Notes:

### I. General Information

Program: Sustainability Semester

Student’s Name: ___________________________________________  Sex:  ____  Birth Date: _____/_____/_____

Name of University/College: _____________________________________________________________________

Campus Address: ________________________________  Phone:  ____________Email: _____________________

Parent/Guardian Name(s): __________________________Phone: _____  Email______________________

Address: _____________________________________________________________________________________

(street address)                                                         (city)                                 (state) (zip)

### II. Current Immunizations

Please list the immunizations you have received since enrolling in college

Date of last tetanus (Td) shot ____________

Hepatitis A ___________ ___________ (dates)

and

Hepatitis B ___________ ___________ ___________ (dates)

OR

Twinrix A/B (Hepatitis A and B combined) __________ ___________ ___________ (dates)

### III. Current Health Questionnaire

**A. General Medical History**

Do you currently have or have a history of:

1. Respiratory problems? Asthma?  [ ] YES  [ ] NO
   - Is the asthma well controlled with an inhaler?  [ ] YES  [ ] NO

If so, please bring one or more metered dose inhalers (MDI) with you for the program

- What triggers an attack? ________________________________
- Last episode? ____________________________________________________________________________
- Ever Hospitalized?  [ ] YES  [ ] NO When? _________________________________________________

2. Gastrointestinal disturbances?  [ ] YES  [ ] NO

3. Diabetes?  [ ] YES  [ ] NO

2-3 Please describe your condition along with necessary treatment: ____________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
4. Bleeding, DVT (deep vein thrombosis) or blood disorders? □ YES □ NO
5. Hepatitis or other liver disease? □ YES □ NO
4-5 Please describe your condition along with necessary treatment: _____________________________
____________________________________________________________________________________
____________________________________________________________________________________

7. Seizures? □ YES □ NO
8. Dizziness or fainting episodes? □ YES □ NO
9. Migraines? □ YES □ NO Are they debilitating? □ YES □ NO
6-9. Describe frequency, date of last episode, severity and medications:
____________________________________________________________________________________
____________________________________________________________________________________

10. Disorders of the urinary or reproductive tract? □ YES □ NO
11. Any disease? □ YES □ NO
12. Do you see a medical or physical specialist of any kind? □ YES □ NO
10-12 If "yes" please specify the issue(s) and necessary treatment(s):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Name of specialist ____________________________
Address ____________________________
Phone Number ____________________________

13. Do you have any physical, cognitive, sensory or emotional condition that would require a special teaching environment? □ YES □ NO
If yes, please describe how the condition affects you: ____________________________
____________________________________________________________________________________

14. Have you been hospitalized in the last two years? □ YES □ NO
If yes, please explain: ____________________________
____________________________________________________________________________________

15. Hypertension? □ YES □ NO
16. Cardiac problems? Unexplained chest pain? □ YES □ NO
15-16 Please describe in detail including any specific prognosis and necessary treatment: _____________
____________________________________________________________________________________

17. Do you currently have or do you have a history within the past 3 years of any type or form of muscular/skeletal injuries (fractures, sprains, dislocations, head injuries, etc)? □ YES □ NO
If yes, please list each occurrence including treatment and any remaining restrictions: ________________
____________________________________________________________________________________
____________________________________________________________________________________

18. Do you have any physical handicap or disability? Do you have any orthopedic or other problems that restrict physical activity? □ YES □ NO
If yes, please describe and list affiliated accommodations required________________________________
____________________________________________________________________________________

Questions 19 and 20 Are For Female Students Only:
15. Treatment or medication for menstrual cramps? □ YES □ NO
16. Are you pregnant? □ YES □ NO
Please describe: ____________________________
____________________________________________________________________________________
B. Physical Fitness
1. Height: ____________ Weight: ____________

2. Do you smoke? □ YES □ NO If so, how much? __________________ per day

4. Do you drink? □ YES □ NO If so, how much alcohol do you consume in a week?: __________________

5. Have you been placed on social or disciplinary probation for an incident in which alcohol or drugs were involved? □ YES □ NO
If yes, please explain: ________________________________________________________________
_________________________________________________________________________________

5. Do you exercise regularly? □ YES □ NO

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<th>Activity</th>
<th>Frequency</th>
<th>Duration/Distance</th>
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C. Medications
1. Are you allergic to any medications? □ YES □ NO
If yes, please list: ________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

2. Do you plan to take any prescription or non-prescription medications on the program? □ YES □ NO

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<tr>
<th>Medication Dosage</th>
<th>Side Effects/Restrictions</th>
<th>Prescribed By?</th>
<th>For What Condition?</th>
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You must understand the use of any prescription medications you may be taking. Written specific instructions are necessary. All Students who are required by their personal physician, psychiatrist or health care provider to take prescription medications on a regular basis must be able to do so on their own and without additional supervision.

If Medication or Condition Changes Prior to Course Start, Please Inform the Director of the Sustainability Semester

D. Allergies
1. Do you have any allergies? □ YES □ NO
Please List Each Allergy, type and severity of reaction, and date of last reaction

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<th>Allergic To:</th>
<th>Description and Severity of Reaction</th>
<th>Date of Last Severe Reaction</th>
<th>Ever Hospitalized? Y/N</th>
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If appropriate please bring a personal supply (>2) of epinephrine preferably in a pre-loaded autoinjector, and know how to use it.

2. Do you have any dietary restrictions? Please specify. □ YES □ NO
□ vegetarian □ vegan □ other: ________________________________
E. Personal History (Counseling/Psychiatric/Learning Disabilities)

1. Have you had treatment, counseling, or hospitalization with a mental health professional? □ YES □ NO
2. Are you currently in treatment or counseling? □ YES □ NO
3. Reasons for treatment or counseling?
   - □ suicide
   - □ ADD/ADHD
   - □ substance abuse/chemical dependency
   - □ family issues/divorce
   - □ eating disorder (anorexia/bulimia)
   - □ depression
   - □ academic/career
   - □ other _____________________

Please provide Specific Dates and details of counseling history and medications that were prescribed:

_____________________________________________________________________________________
_____________________________________________________________________________________

4. Name and telephone number of therapist(s):

Name ___________________ Phone ___________________

5. Are you currently, or have you recently been, involved in friend/family relationships that have caused you unusual stress? □ YES □ NO
   If yes, please explain: ___________________________________________________________________
   ________________________________________________________________________________

F. Physician Report

1. Do you have any significant chronic medical conditions requiring on-going medical supervision and treatment or have you had in the past any significant chronic medical conditions which are currently in remission? □ YES □ NO
   Please List: __________________________________________________________________________

2. Are you currently receiving, or have you received in the past two years, counseling in the treatment of any emotional challenge, drug addiction, alcohol problem, psychiatric condition, or eating disorder? □ YES □ NO

If you answered YES to either or both of these questions, you must have the medical practitioner(s) primarily responsible for your care complete Part 3: Physicians/Counselor Report and submit it to the Sustainability Semester by November 26th

To the best of my knowledge, I am physically and mentally capable of participating in this course and am not aware of any medical conditions that would prevent me from participating in this course. I affirm that all information provided is accurate and complete to the best of my knowledge.

____________________________________________________       _______________________________________________
Signature of Applicant                                                                                           Date

______________________________________________    _____________________________________
Signature of Parent/Guardian (if applicant is under 18 y/o/a)                        Date

RETURN COMPLETED FORM TO:  SUSTAINABILITY SEMESTER/OUTDOOR STUDIES
ATTN: SHERRIE KELLY
ST. LAWRENCE UNIVERSITY
23 ROMODA DR.
CANTON, NY 13617
Fax: (315) 229-5019
PART 2: MEDICAL RELEASE

All students must complete this form and return it to:
SUSTAINABILITY SEMESTER/OUTDOOR STUDIES
ATTN: SHERRIE KELLY
ST. LAWRENCE UNIVERSITY
23 ROMODA DR.
CANTON, NY 13617
Fax: (315) 229-5019

Student Name __________________________________________________________________

I give permission for St. Lawrence University Health Center staff to discuss my medical/psychological records with the Director and Assistant Director of the Sustainability Semester.

Signature _________________________________________ Date ________________
**PART 3: PHYSICIAN/COUNSELOR REPORT**

To be completed by your primary physician/counselor providing treatment if applicant answered ‘yes’ to Section F: Physician Report, Items 1 and/or 2

You are receiving this form because an applicant to the St. Lawrence University Sustainability Semester indicated that she/he has or had either a chronic medical and/or an ongoing psychiatric condition(s) for which she/he needs or has recently needed ongoing medical care. In the interest of the personal safety of both the applicant and the other members of the Sustainability Semester, you are being asked to assess this student on this condition(s) and give your medical opinion as to whether or not you believe this student is capable of safely participating in this program. If any questions remain regarding the student’s capacity to successfully participate in our program following your assessment, we will call the student to discuss it.

The Sustainability Semester is not a rehabilitation program. It is not the place to quit smoking, drinking or drugs or to work through behavioral or psychological problems.

**Physician’s Notes:** If additional space is required, please attach report.

Applicant’s Name ___________________________ Program: Sustainability Semester

Diagnosis:

Medications and dosages:

Diet:

Stability of condition over past two years:

Based on the medical and personal conditions determined during your assessment of the applicant, do you have any recommendations for the care of this individual?

General Appearance, Health, Impressions, and Comments:
By my signature, I attest that the information in this form is correct and that based the background information provided by the applicant and my physical examination of him/her (please check one):

☐ I believe this individual capable of participating on the Sustainability Semester
☐ I do not believe this individual capable of participating on the Sustainability Semester

_____________________________________________________________  _______ /______ /_____
Physician/Counselor’s Signature  Date:

______________________________________________________________
Physician/Counselor’s Printed Name  Phone

Street Address  State  Zip

______________________________________________________________
Email  Fax

Please Return Form by November 26th to:
Sustainability Semester/Outdoor Studies
Attn: Sherrie Kelly
St. Lawrence University
23 Romoda Drive
Canton, NY 13617
Fax: (314)229-5019
skelly@stlawu.edu

- For more information on program conditions, please contact the Outdoor Studies Department at (315) 229-5015.
- With any questions or concerns of a medical nature, please contact the Winning Health Center at (315)-229-5392