



## OSEA Medical Release

As participant in OSEA Summer Ethnography Field School, I, \_\_\_\_\_, agree to freely provide OSEA this medical release form that contains private information about my health and medical conditions. I understand that OSEA requires and only uses this information in order establish any necessary precautions for my health, well-being, safety during my participation in the OSEA program.

\_\_\_\_\_  
Print Name Signature Date

### Pre-Departure Medical Evaluation

To be completed by the examining Physician or Health Care Practitioner

To the Physician or Health Care Practitioner:

The purpose of this form is to help OSEA to be of maximum assistance to the student participant should the need arise during his or her study abroad. Mild physical or psychological disorders can become serious under the stresses of life while studying abroad. It is important that the program coordinator be made aware of any medical or emotional problems, past or current, which might affect the student in a foreign study context. This information does not affect his/her admission into the OSEA study abroad program and will remain confidential and shared with the program staff, faculty, or appropriate professionals only if pertinent to the student's well-being. The programs of OSEA are located in Yucatán, México, City of Mérida, Town of Pisté and other rural and urban locations and communities in the states of Yucatán, Campeche, and Quintana Roo, México

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_

When did you last examine the applicant? \_\_\_\_\_

Applicant's general state of health. (check one)                      Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

Height \_\_\_\_\_ Weight \_\_\_\_\_

Does the student manifest any health issues in relation to weigh and size? Please explain

\_\_\_\_\_  
\_\_\_\_\_

Does the student have or had any medical or health issues that require periodic medication or treatment? If yes, please describe condition, frequency and nature of treatment, and specific health precautions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student LAST NAME, First name \_\_\_\_\_

Does the student have any condition which could limit his/her participation in Field Study Abroad because of or in relation to climate, altitude, flora or fauna or other similar factors? If yes, please describe:

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Does the student have any allergies to food, vegetation, animals, or medicine about which a homestay family must be aware of in order to prevent or minimize specific allergens in the student's living and eating situations:

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Does this student have any physical or emotional condition, disability, or impairment that might cause hardship during an extended stay abroad? If yes please describe:

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Please note any other additional information, including details of current treatment, if any, which could be helpful to the physician who would be treating this student while abroad:

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I have discussed with this student the CDC immunization, vaccination or prophylaxis requirements and the CDC summary of health & sanitation conditions and the potential impact of these on his/her health.

To the best of my knowledge, the above named student has no physical or mental illnesses that should prevent him/her from participating in the study abroad program. \_\_\_ Yes \_\_\_ No (please explain)

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*Physician's or Health Care Practitioner's Contact Information*

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Name of Healthcare provider (Print)

Signature

Date

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Clinic Name and Address (Street Address, City, State, Zip code)

Telephone number / email \_\_\_\_\_