CONNECTICUT COLLEGE - STUDENT HEALTH SERVICES

TRIPS HEALTH SCREENING FORM

Name: _____ Class Year: _____ Date of Birth: _____

Phone: _____ E-Mail:_____

PROGRAMS APPLYING TO:

Program Name	Location/ area of Program	Dates of Departure & Return
1.		
2.		
3.		

HEALTH HISTORY

Please fill out this form and answer all questions truthfully. Accurate information will help us in preparing you properly for your TRIPS experience.

Do you now or have you ever had:	YES	NO	Please Explain all YES answers:
1. Allergic Reaction to any medications or foods?			
2. Have you had a recent physical exam?			**Date of Exam:**
3. Have there been any changes in your health since your entrance to Connecticut College?			
Hospitalizations?			
Injuries?			
Surgeries?			
Illnesses?			
4. Counseling or Treatment with a counselor or psychiatrist in the past five years?			
5. Diagnosed with Anxiety or Depression?			
ADD or ADHD?			
Anorexia or Bulimia?			
6. Do you drink alcohol?			**How many nights a week? _____** **How many drinks a night? _____**
7. Do you smoke cigarettes?			**Number of cigarettes per day? _____**
8. Take medication on a regular basis? **Medications** **1.** **2.** **3.`**			**Reasons for taking:**
9. Will you need to take your prescriptions while abroad?			
10. Are there any aspects of your health that may require special arrangements while abroad?			
11. Do you have any other health concerns that you would you like to discuss with student health Services?			**If YES, Call x2275 to schedule an appointment**

I hereby verify that the information contained in this form is accurate and complete:

Student Signature: _____ **Date**: _____

Reviewed by: _____ Date: _____

Approved: ☐ YES , office notified, Date: _____ Initials_____ ☐ NO , Appointment Needed