International Center for the Arts
Emergency contact & Medical Information Form

All information given below is requested in order to provide for your comfort and safety and to assist in case of an emergency. This information is confidential and private and will not be shared with any other parties, except emergency medical personnel.

Personal Information

Name_ ____

Gender__________ Birth date______________________

Address in my home country ____

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Program title____

Session Dates ____

Emergency Contact Information

Person to contact in an emergency

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Telephone______________________ Relationship_______________________________

Address____

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Cell___________________ Home___________________ Work____________________

Authorization to Release Health Records and Permission for Emergency Medical Treatment

Please complete and sign the following:

During my residence in Monte Castello di Vibio, Umbria (PG) Italy, I,

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authorize the release by The Italian Center for the Arts the medical information pertaining to me contained in the below to health care professionals in the event of an emergency.

Signature of applicant____

Date_________________________________
month/day/year

Printed name____

Program title____

Personal Health History

Review of Illnesses and Symptoms

Please complete the following, adding additional paper if necessary. DO NOT LEAVE ANY QUESTION BLANK.

A. Have you consulted or been treated by clinics, physicians, or other practitioners within the past two years (other than routine check-ups)? If yes, give details.
yes no

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B. Have you ever been hospitalized or had a serious acute illness? If yes, give diagnosis and date. yes no

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C. Do you have any chronic/recurrent illness? Any permanent/chronic injury or physical disability? If yes, give details. yes no

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D. Have you had any allergic reaction to past immunizations, prescription, or over-the-counter medicines? If yes, give details. yes no

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E. Do you have a history of asthma or other respiratory ailment? If yes, give details. yes no

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F. Are you currently taking any medications including prescription, over-the-counter, and herbal remedies for any medical, psychological, or other conditions? If yes, list and give details. yes no

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G. Do you have any health requirements or dietary restrictions? If yes, explain. yes no

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H. In the last two years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, for any mental, emotional or psychological conditions including eating disorders and substance abuse? If yes, give details. yes no

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<u>Please check if you have had:</u>

Allergy (please specify):
- Hay fever
- Bees/wasps
- Pet/animal dander
- Foods___________________
- Other ___________________

Eye or Vision issues
Hearing loss
Anemia
Bleeding/Clotting
Bladder/kidney problems
Cancer or Leukemia
Immune System problems
Heart problems
Diabetes
Back problems
Painful swollen joints
Abdominal pain
Chronic indigestion, diarrhea
Stomach ulcer
Impaired use of any limbs
Epilepsy (seizures)
Recurrent dizziness/faintness
Severe headaches/migraines

Please explain if you have been, or are being, treated for any of the above. Include information on regular treatment medications.

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