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SEMILLA CASAS Programs Health Screening Form - Part 1

Applicant Name

SEMILLA CASAS Program
- ☐ Study Abroad
- ☐ Spanish in Guatemala
- ☐ Learning Tour
- ☐ Gap Program
- ☐ Sabbatical
- ☐ Family Experience

Date of Birth:	MM/DD/YYYY	**Gender:**	☐ Male	☐ Female
Travel Start	MM/DD/YYYY	**Travel End:**	MM/DD/YYYY	

HEALTH SCREENING REQUIREMENTS

Less than 30 Day CASAS Program

ALL participants who participate in a SEMILLA CASAS Program in Guatemala must complete Part 1 of the Health Screening Form. This form must be signed and returned to the SEMILLA CASAS Program Director before the participant is approved to participate in a SEMILLA CASAS Program. This confidential information will be used in case of an emergency.

More than 30 Day CASAS Program

All participants who plan to participate in a SEMILLA CASAS program for more than 30 days must be medically cleared to participate in SEMILLA CASAS Programs for an extended period of time. Copies of this form are to be retained by both the healthcare professional and the participant as a confidential medical record.

INSTRUCTIONS TO THE PARTICIPANT

Please complete the general health survey questions in **PART I** below to the best of your ability. Applicants participating in an extended stay program must submit this form to the examining physician or health care provider, who will complete **PART II.**

PART I: MEDICAL INFORMATION

1. **General Health**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. **Allergies**
   - ☐ Penicillin
   - ☐ Aspirin
   - ☐ Bee stings
   - ☐ Peanuts
   - ☐ Eggs
   - ☐ Pollen
   - ☐ Other Allergies (give details):

3. **Diet**
   - ☐ Regular
   - ☐ Vegetarian
   - ☐ Vegan (Plant-based foods only)
   - ☐ Other Diet Restrictions (give details)

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4. Prescribed Medications

	Name/Dose
☐ Vitamins	
☐ Birth Control	
☐ Seizure	
☐ Depression/Anxiety	
☐ Inhalers	
☐ Insulin injections/pump	
☐ Other medications prescribed for medical or mental health conditions: (give details)	

5. Devices

☐ Contact lenses or eyeglasses
☐ Hearing aid ☐ Right ☐ Left

☐ Prosthetic joints or devices (give details)	
☐ Other devices (give details)	

6. Hospitalization/Surgical History

Have you had surgery or hospitalization within the last 18 months? If so, please describe it.

☐ Hospitalization (give dates and type)	
☐ Surgery (give dates and type)	

7. Other Health Conditions

☐ Asthma
☐ Anxiety/Depression
☐ Cancer/tumors
☐ Anorexia/Bulimia
☐ Heart Problems
☐ High Blood Pressure
☐ Alcohol or other substance abuse
☐ Ulcer/stomach problem
☐ Bladder/kidney problem
☐ Back/joint problems
☐ Anemia or bleeding disorder
☐ Hepatitis/jaundice
☐ Migraine headaches
☐ Thyroid problems
☐ Other serious health considerations (describe)

Please describe condition/treatment:

8. Mental Health Treatment

Have you been treated by a psychiatrist, psychoanalyst, psychologist or therapist for any mental, emotional, or nervous disorder within the past 5 years?*

☐ Yes
☐ No

**If yes, and you are applying for more than a 30-day CASAS program, your mental health care provider must clear you for travel by signing on the bottom of the last page in the space labeled "signature of specialist or psychotherapist".*

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Immunization Record

Indicate the date of your last immunization for each item. Participants are advised to carry a copy of their official immunization record while traveling.

- ☐ Tetanus Booster _____
- ☐ Typhoid _____
- ☐ Meningococcal _____
- ☐ Polio _____
- ☐ Hepatitis A _____
- ☐ Hepatitis B _____
- ☐ Varicella/Chicken Pox____
- ☐ Measles/Mumps/Rubella____
- ☐ Yellow Fever_____
- ☐ COVID-19_____

Disability/Mobility Accommodations

SEMILLA CASAS Program is committed to providing services to participants with disabilities in as much as feasible. Do you anticipate requiring disability-related accommodation(s) while abroad?

- ☐ Yes
- ☐ No

If yes, please describe:

EMERGENCY CONTACT INFORMATION

Name	
Email	
Phone	
Address	
Relationship to you	

STATEMENT AND RELEASE OF INFORMATION

- ☐ The answers I have given are correct and complete to the best of my knowledge.
- ☐ I understand that the information included on all pages of the Health Screening Form and any additional medical information submitted to the SEMILLA CASAS Program may be shared with employees, faculty, agents, or other designated officials for the purpose of protecting my health during the period of my participation in the program identified on the form, or in the case of a medical emergency abroad.

Signature of participant: Date: