**Incoming Student - Medical Form**

**International Mobility Program**

The International Programs and Intercultural Education Office requires that the applicant/student be able to inform about any special condition/requirement in order to give each student the best support during his/her time at UIDE. Especially If the student will be hosted in our residences or by our host family program. Please use the table listed below to verify that the applicant can meet the stated essential functions.

*(To be completed by student)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of function** | **Essential function** | **Limited/Non-limited** | **Comments or accommodations needed** |
| Visual perception | Observe student and teacher responses at a distance and close at hand. | Yes\_\_ No\_\_ |  |
| Auditory perception | Detect audible sounds. | Yes\_\_ No\_\_ |  |
| Physical endurance | Stand, walk and/or sit for 6-8 hours a day. | Yes\_\_ No\_\_ |  |
| Communication ability | Interact effectively with others, both verbally and writing. | Yes\_\_ No\_\_ |  |
| Emotional stability | Perform multiple responsibilities concurrently. | Yes\_\_ No\_\_ |  |
| Cognitive ability | Read, write, speak and comprehend the English language.Read, write, speak and comprehend the Spanish language. | Yes\_\_ No\_\_Yes\_\_ No\_\_ |  |

I certify to the best of my ability that the above information is true.

Name of applicant: Date:

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

**FAMILY & PERSONAL HEALTH HISTORY** *(To be completed by student)*

Has any person related by blood, had any of the following:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Relationship |  | Yes | No | Relationship |
| Stroke |  |  |  | Diabetes |  |  |  |
| Heart attack before age 55 |  |  |  | Glaucoma |  |  |  |
| Blood or clotting disorder |  |  |  | Alcohol/drug problems |  |  |  |
| Cancer (type): |  |  |  | Psychiatric illness |  |  |  |
| Suicide |  |  |  |  |  |  |  |
| High blood pressure |  |  |  | Cholesterol or blood fat disorder |  |  |  |

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

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence).

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No | Year |  | Yes | No | Year |  | Yes | No | Year |
| High blood pressure |  |  |  | Thyroid trouble |  |  |  | Disabling depression |  |  |  |
| Rheumatic fever |  |  |  | Diabetes |  |  |  | Paralysis |  |  |  |
| Ulcer (duodenal orstomach) |  |  |  | Gall bladder trouble or gallstones |  |  |  | Excessive worry or anxiety |  |  |  |
| Pain or pressure in chest |  |  |  | Mononucleosis |  |  |  | Asthma |  |  |  |
| Shortness of breath |  |  |  | Frequent vomiting |  |  |  | Intestinal trouble |  |  |  |
| Serious skin disease |  |  |  | Allergy injection therapy |  |  |  | Pilonidal cyst |  |  |  |
| Pneumonia |  |  |  | Arthritis |  |  |  | High fever |  |  |  |
| Chronic cough |  |  |  | Concussion  |  |  |  | Malaria |  |  |  |
| Head or neck radiation |  |  |  | Frequent or severe headache |  |  |  | Jaundice or hepatitis |  |  |  |
| TreatmentsTumor or cancer (specify) |  |  |  | Dizziness or faintingSpells |  |  |  | Rectal disease |  |  |  |
| Bone, joint or otherDeformity |  |  |  | Severe head injury |  |  |  | Severe or recurrentabdominal pain |  |  |  |
| Hernia |  |  |  | Sinusitis |  |  |  | Back injury |  |  |  |
| Easy fatigability |  |  |  | Knee problems |  |  |  | Heart trouble |  |  |  |
| Anemia or sickle cell |  |  |  | Recurrent back pain |  |  |  | Kidney infection |  |  |  |
| Eye trouble besidesneed glasses |  |  |  | Broken bone(specify) |  |  |  | Bladder infection |  |  |  |
| Kidney stones |  |  |  | Protein or blood in urine |  |  |  | Hearing loss |  |  |  |
| Smoke 1+ pack cigarettes/week |  |  |  | Severe menstrual cramps |  |  |  | Irregular periods |  |  |  |
| Sexually transmitted |  |  |  | Blood transfusion |  |  |  | Alcohol use |  |  |  |
| Anorexia/Bulimia |  |  |  | Neck injury |  |  |  | Drug use |  |  |  |

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_ Use \_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_ Use \_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_ Use \_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage \_\_\_\_\_\_\_\_\_\_\_\_\_

Medication recommended in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | List allergies |
| **Allergies** |  |  |  |

**FAMILY & PERSONAL HEALTH HISTORY-CONTINUED** *(To be completed by student)*

Check each item “Yes” or “No.” Every item checked “Yes” must be fully explained in the space on the right (or on an attached sheet). Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

|  |  |  |  |
| --- | --- | --- | --- |
| Adverse reactions to | Yes | No | Explanation |
| Penicillin |  |  |  |
| Sulfa |  |  |  |
| Other antibiotics (name) |  |  |  |
| Aspirin |  |  |  |
| Codeine |  |  |  |
| Other pain relievers (name) |  |  |  |
| Other drugs, medicines, chemicals (specify) |  |  |  |
| Insect bytes |  |  |  |
| Food allergies (name) |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Explanation |
| Do you have any conditions or disabilities that limit your physical activities?  |  |  |  |
| Has your academic career been interrupted due to physical or emotional problems?  |  |  |  |
| Is there loss or seriously impaired function of any paired organs? |  |  |  |
| Have you ever had any serious illness or injuries other than those already noted? |  |  |  |

**FOOD HABIT AND PREFERENCES**

Please let us know about your diet preferences:

Vegan\_\_ Vegetarian \_\_ Others (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dietary restriction, are you allergic to some component? If yes, please specify:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VACCINES TO TRAVEL INSIDE ECUADOR**

Immunization against COVID 19 is necessary to participate in UIDE international programs, in addition, the vaccination certificate will be requested by the migration authorities for entry into the country.

There are no vaccines mandatory to enter Ecuador, despite this, there is a strong recommendation from the Ecuadorian Ministry of Health to apply certain vaccines:

This vaccine is strongly suggested:

The **yellow fever vaccine** is mandatory for those travelers who come from a country where this disease is considered endemic: some regions of Africa and Latin America (Argentina - Bolivia - Brazil - Colombia - Ecuador - French Guiana - Guyana - Panama - Paraguay - Peru - Suriname - Trinidad and Tobago - Venezuela). Being caused by a virus that is transmitted through the bite of the Aedes aegypti mosquito in tropical regions. This vaccine should be applied up to 10 days before entering Ecuador.

The yellow fever vaccine is also recommended to be applied when visiting the provinces of the eastern Andes, at altitudes below 2300m, corresponding to: Morona Santiago, Napo, Orellana, Pastaza, Sucumbios and Zamora Chinchipe. To visit other places in Ecuador, such as Quito, Guayaquil or the Galapagos, this vaccine is not recommended.

These vaccines are recommended:

It is advisable to have certain vaccines up to date to protect against diseases of worldwide distribution, among them are the **Tetanus-diphtheria-pertussis v**accine, the **Triple Viral** (Measles, rubella, mumps) and **Hepatitis A**.

**Hepatitis B** is suggested for special conditions, such as travelers who practice risk activities, where blood or other body fluids may come into contact. There are high rates of chronic infection in the Amazon basin.

The **typhoid fever** vaccine is also recommended as this disease can be contracted if you visit places with poor hygienic conditions linked to food handling and water quality.