208 E Cedar St, Livingston, NJ; www.lithuanian-american.org
Phone: (203) 773-1257 * Fax: (973) 994-2101 * E-mail: liss@lithuanian-american.org

The Lithuanian-American Community, Inc. Internship in Lithuania Program

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Health Information Form

General and Emergency Contact Information

Name: _____Gender: _____

Physician's Contact Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel.: _____ EMAIL: _____ Cell: _____

Clinical History:

NOTE: If you answer "yes" to any of the following questions, you must complete and return the Physician's Report Form on p. 4. In the case of multiple medical and/or mental health conditions, please submit separate forms for each. Please contact us if any conditions or treatments significantly change before the start of your program.

- Are you currently under medical treatment?
  Yes No
- Do you have a chronic medical condition (asthma, diabetes, IBS, Crohn's, etc.)?
  Yes No
- Have you had any diseases, surgical operations or significant injuries within the last five (5) years that could have an effect on your participation in this program?
  Yes No
- Have any surgical operations been recommended that could have an effect on your participation in this program?
  Yes No
- Do you plan to have any surgical operations between now and your date of departure?
  Yes No
- Have you had any psychological, psychiatric, or personal issues (including eating disorders, substance abuse, family concerns) during the past five (5) years for which you have sought professional attention?
  Yes No

Please list the conditions:

Are you currently taking any medications?_____
Yes No

If yes, please list name, dosage, and prescribing physician and, if not listed above, contact information for that physician.

NOTE: Please return the Physician's Report form on p. 3 if you are taking prescriptions for a medical or psychiatric condition or for depression, anxiety, or other psychological/emotional condition. You do not need to return the form on p. 3 for routine prescriptions such as skin care, birth control or allergies.

Name of medication	**Date med begun**	**Dosage & frequency**	**Date will stop med**	**Condition treated with med**	**Prescribing Physician and contact information**

- Have you contacted your clinician and health insurance provider to obtain a sufficient dosage of this medication for the duration of your internship program? **Yes No**

If "no" please list date when this contact will be made: _____

1. Please list any allergies to medication, food or other substances/conditions:

2. Please list any dietary restrictions:

3. Is there anything else about your health or medical history that may be a factor should there be an emergency?

   Yes No If yes, please explain:

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To be completed by a physician, psychiatrist, psychologist or counselor who has treated this high school student for the condition described below.

_____ (high school student's name) has identified a chronic and/or recurrent health issue. Please evaluate the physical and/or mental health of this high school student, who intends to participate in an internship abroad program in Lithuania. The availability of medical services in the country and areas where the high school student will be living/traveling should be considered.
NOTE TO STUDENT: If you have multiple medical/mental health conditions, a separate form must be submitted for each.

I have treated this individual for this condition:
within the past six months within the past year more than one year ago

(please specify date): _____
Diagnosis:

Medications and dosage:

Stability of condition over the past five (5) years:
stable without treatment/medication stable with treatment/medication not stable
other: _____

In your professional opinion, is this student fit for an internship abroad lasting 6 weeks? Yes No

To your knowledge, are there any predisposing medical, physical, or emotional factors that, under stress of adjusting to life in another country, may require treatment while the student is abroad? Yes No

Recommendations for care of this individual while abroad:

Physician's (or representative's) Signature:
Printed Name:
Address:
City: State/Region: Zip:
Telephone: Fax:

Please complete and return to:

Lithuanian-American Community, Inc.
ATTN: LISS program
208 E Cedar St
Livingston, NJ 07039