University of Washington
IFSP-Indonesia 2018
Health Card

DATE:_____

NAME (full): _____ (nickname): _____

1. Emergency Contacts (name, phone, email):

   1)_____

   2)_____

2. Health/Accident Insurance (company name, phone, policy no.):

   1)_____

   2)_____

3. Blood type: _____

4. Corrective lenses: _____

5. Known allergies: (e.g., food, meds, insects) (list): _____

6. Prescribed medications (list): _____

7. Internal organs removed (eg. appendix, spleen, kidney) (list): _____

8. History of asthma / other respiratory ailments (list):_____

9. History of diabetes / high blood pressure (list): _____

10. Immunizations in past 5 yrs (list with dates): _____

Should I require medical treatment as a result of accident/illness arising during the foreign study program, I consent to such treatment. Signature:_____ date:_____

I understand that I am neither obligated nor required to disclose to IFSP-Indonesia information relating to ques. 3-10.

USE BACK OF PAGE IF NEEDED