FieldWorks: Medical Form Page 1

This form must be completed and returned to before February 1st, 2021 (Spring) or August 16th, 2021 (Autumn)

Cow House Studios,
Ballybawn, Rathnure, Enniscorthy,
Co. Wexford, Ireland

Section 1: Physicians Medical Statement
This section must be completed by your family physician.

Student Name: ______________________ Birth Date: ______________

Physician: The student listed above is registered to attend FieldWorks gap year program at Cow House Studios in Ireland. While the primary activities involve making art, he/she may also engage in outdoors activities such as swimming, biking, and hiking. If you have any questions, please contact us at: 1 800 677 0628.

Physical limitations or restrictions: ______________________
Surgeries or serious illnesses: ______________________
Disabilities or chronic medical conditions: ______________________
Dietary restrictions: ______________________
Psychological conditions we should be aware of: ______________________

Health History Check and give approximate dates

Frequent Ear Infections: ☐ ______________
Heart Defect/Disease: ☐ ______________
Convulsions: ☐ ______________

Bleeding/Clotting Disorders: ☐ ______________
Hypertension: ☐ ______________
Mononucleosis: ☐ ______________

Diseases
COVID-19 ☐ ______________
Chicken Pox: ☐ ______________
Measles: ☐ ______________
Mumps: ☐ ______________
German Measles: ☐ ______________

Allergies
Insect Stings: ☐ ______________
Penicillin: ☐ ______________
Other Drugs: ☐ ______________
Other: ☐ ______________

Immunization History: List dates of basic immunizations and most recent boosters.
Polio: __________ DPT: __________ Hepatitis B: __________ TB: __________
Tetanus: __________ Varicella (Chicken Pox): __________ MMR (Measles-Mumps-Rubella): __________
COVID-19: __________

Medications to be taken while at Cow House Studios:
Medication: __________ Dosage: __________ When to take: __________
What is this medication prescribed for or treating? ______________________
Medication: __________ Dosage: __________ When to take: __________
What is this medication prescribed for or treating? ______________________
Medication: __________ Dosage: __________ When to take: __________
What is this medication prescribed for or treating? ______________________
Medication: __________ Dosage: __________ When to take: __________
What is this medication prescribed for or treating? ______________________

Are there medications currently taken that will be suspended while in Ireland? Why? ______________________

____

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Cow House Studios
Ballybawn
Rathnure
Enniscorthy
Co. Wexford
Ireland

Phone: +353 53 916 9567
Fax: +353 53 916 9610
US Toll Free: 1 800 677 0628

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www.cowhousestudios.com

FieldWorks: Medical Form Page 2

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Physicians Medical Statement Continued

Are there any restrictions to his/her activities or precautions which should be taken? ____________

Is he/she currently under the care of a physician for a specific condition? If so, what? Is the treatment to be continued while he/she attends the program in Ireland? ____________

Does he/she have epilepsy? ____________
Does he/she have diabetes? ____________
Does he/she have any allergies? (food, medical, insect & other?) ____________

Are there any other health related issues we should know about regarding this child? ____________

Is there any other information, medical or otherwise, that would help us to provide a safer, more productive and enjoyable summer for this child? ____________

Doctor Name: ____________
Phone number: ____________ Fax number: ____________
Address: ____________
Doctor Signature: ____________ Date: ____________

Section 2: Parents & Students

Is there anything not mentioned above (medical or other) that we should know about to assist us in providing you a healthy, happy, productive and safe trip? ____________

Permission is hereby given for CHS to authorize medical, dental or hospital attention to be given to me. Matters of any severity will be discussed with my parents/guardians as promptly and reasonably possible. In signing this medical form, I give permission for medical, dental or hospital attention to be given to me and attest that all information on this form is complete and correct and that I have listed all relevant insurance information below.
Student Name: ____________
Student Signature: ____________ Date: ____________
Parent Name: ____________
Parent Signature: ____________ Date: ____________
Alternate emergency contact & relationship to student (other than parents): ____________

Emergency contact phone: ____________ Emergency contact email: ____________

Student Insurance Information:

All students must have medical insurance for the duration of their stay at Cow House Studios. **Attach a copy of your insurance certificate/ card with this form.**
Company name: ____________ Phone number: ____________
Address: ____________ Policy/ Reference Number: ____________

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