Travel Abroad Physician's Statement

FLORIDA SOUTHWESTERN STATE COLLEGE
INTERNATIONAL EDUCATION CENTER

Student Name _____ **Date of Birth** _____

Program & Country of Study _____

Dates of Travel _____

To the Examining Physician:
Participating in a Travel Abroad Program may tax a student's physical and mental capabilities to the fullest. Therefore, it is imperative as a safeguard to the health of the participant, that this report be as complete and accurate as possible.

Please mark all historic or current physical or mental health conditions which apply:

- ☐ ADHD
- ☐ Allergies of any kind*
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Cancer or Tumors
- ☐ Chronic Respiratory Problems
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness/fainting Spells
- ☐ Dyslexia
- ☐ Epilepsy or Seizures
- ☐ Head Injury
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Liver/Gall Bladder Problems
- ☐ Neurological Condition
- ☐ Post-Traumatic Stress Disorder
- ☐ Skin Disease/Disorder
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Other*

***If yes to allergies or other, please list/explain below.**

_____

Please indicate any operations, injuries, treatments sustained by/administered to the student.

Operation, Injury, Treatment, etc. _____ **Date(s) of incident, treatment, etc. (month/year)** _____

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Please indicate any prescription medication the student may be taking and the related ailment(s).

Medication	Purpose of Medication	Date Prescribed (month/year)
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Do any medications need refrigeration?

If yes, to refrigeration, list medications here

Physician's release to participate:

I have examined the student named above and believe that he/she is physically and emotionally qualified to participate in a travel abroad program. He/she presents no evidence of communicable disease, of over-fatigue or any other physical or mental condition which would affect the quality of his/her academic performance or experience abroad.

In my judgment, he/she is not likely to need medical or surgical attention during the proposed period of travel abroad as the result of any treatment, disease, operation, or injury heretofore experienced.

Physician Name:_____ Date:_____

Physician Signature:_____

Address:_____

Telephone Number:_____ Fax Number:_____

Student release of information:

I understand that this health information will be shared with the Center for International Education and the onsite study abroad program coordinator. I acknowledge that my health information may also be shared with additional parties in the event of an emergency.

Student Signature:_____ Date:_____

Parent/Legal Guardian Signature (If Student is Under Age 18):_____