

MEDICAL APPROVAL FORM

(PART II: THIS SECTION TO BE COMPLETED BY A HEALTHCARE PROVIDER)

SECTION D: PHYSICIAN EVALUATION

Weight _____ Height _____ Temperature _____ Pulse _____ Blood Pressure _____

Urine: S.G (optional) _____ Urine: Protein (optional) _____ Lab: HGB/HCT (optional) _____ Blood Glucose (optional) _____ Other (optional) _____

Corrected RIGHT vision 20/____ Uncorrected RIGHT vision 20/____

Corrected LEFT vision 20/____ Uncorrected LEFT vision 20/____

Are there any abnormalities of the following: If yes, indicate in space below. Please indicate if not evaluated.

- | | | | | | |
|------------------------------|-----------------------------|-------------|------------------------------|-----------------------------|------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lungs/Chest | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nose/Throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Abdomen |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immune System |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouth | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gastrointestinal |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Musculoskeletal |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ears | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological |

SECTION E: MEDICAL APPROVAL

- Agree Disagree I have discussed with this participant, relevant vaccinations & immunizations that may be needed in relation to his/her medical needs, travel destination(s), itinerary, and planned activities.
- Agree Disagree I have examined this participant, or the records of this participant, and believe that his/her health, including mental and physical, **will permit** him/her to successfully participate in a study abroad program

If you DISAGREE with the above statement, please indicate why you feel that the participant is **NOT capable** of having a successful study abroad experience: _____

Please indicate if, while abroad, the participant will need any accommodations or support to assist him/her with any medical conditions (physical or emotional): _____

Do you have any recommendations regarding the care of this student while he/she is abroad (emotional or physical)? _____

SECTION F: PHYSICIAN SIGNATURE AND CONTACT INFORMATION

Physician Signature: _____ Date: ____/____/____

Printed Name _____ Phone: ____-____-____

Clinic Address or Stamp: _____
Street Address City, State Zip

**Submit Completed Form on or before April 1st to:
College of Arts and Sciences Dean's Office, Admin Building, Room 230**