



**CONFIDENTIAL PHYSICIAN'S REPORT: Due Upon Acceptance**

**Name of applicant:** \_\_\_\_\_ **College or University:** \_\_\_\_\_

**Applicant's email:** \_\_\_\_\_

**To the student:** Your health and safety while traveling and abroad are of the utmost importance of us, and self-disclosure of your health history and current concerns, if any, are essential to your well-being. This form will inform the HCAYS / HiF of any physical or psychological condition which may affect you while abroad, and to provide essential information to medical personnel in Spain or France in case of an emergency. This information should be accurate, current and complete. Please do not disguise or hide any issues. The information will be shared with personnel in Spain and France, medical personnel or hosts, if necessary, and except in unusual cases, answers will not affect your selection to the Programs. Please be certain to complete pages 1 and 2.

**Authorization:** I authorize my physician to provide information regarding the status of my health to the staff of the Hamilton College Academic Year in Spain or Junior Year in France, and I authorize the HCAYS or HiF staff to consult with my physician, if necessary. I have disclosed all pertinent health information, physical and psychological, and any treatment and medications I have taken within the past five years. If I develop any medical or psychological condition subsequent to enrolling with the HCAYS or HiF, I agree to disclose this information to the HCAYS or HiF personnel, and agree that the staff will share the information with my host, if necessary.

**Student's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**To the physician:** Sound physical and emotional health is important to successful study abroad. We request your careful and complete evaluation of the applicant's health.

Applicant's general state of health (please circle all replies):    **Excellent**        **Good**        **Fair**        **Poor**

Student's date of birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Is the applicant seriously overweight or underweight?	<b>Yes</b>	<b>No</b>
Any dietary restrictions (medical / personal preference)?	<b>Yes</b>	<b>No</b>
Allergies:	<b>Yes</b>	<b>No</b>
Prescriptions / medications (please list on next page)	<b>Yes</b>	<b>No</b>
History of physical or emotional challenges that may cause hardship abroad?	<b>Yes</b>	<b>No</b>

(Please explain)

Communicable diseases including HIV / AIDS	<b>Yes</b>	<b>No</b>
Psychiatric treatment within the last four years?	<b>Yes</b>	<b>No</b>
Currently in treatment for physical or emotional condition?	<b>Yes</b>	<b>No</b>
Serious eyesight, hearing or speech impairment?	<b>Yes</b>	<b>No</b>
Other medical, emotional or physiological conditions that might cause problems?	<b>Yes</b>	<b>No</b>
<b>Any additional information that we should know?</b>	<b>Yes</b>	<b>No</b>

**Name of applicant:** \_\_\_\_\_ **College or University:** \_\_\_\_\_

**To the physician (continued):**

1. If you have answered **Yes** to any of the previous questions, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. If the student is not currently treated for any illness, but has received treatment within the past four years, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. If the student will need treatment in Spain or France, please have the current attending physician explain the treatment requirements. In addition, do you have a contact or facility in Paris or Madrid where the treatment may continue?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. If the student will need prescription medicine while in Spain or France, please indicate that the student will take a sufficient amount of medication for the duration of the Program, and whether the medication is available in Spain or France.

5. If you have any other comments or remarks not included with this evaluation, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Please verify with your signature that you have discussed the physical and psychological demands of study abroad with this student, that you have reviewed the student's responsibility regarding study abroad, that if necessary, you are willing to consult with HCAYS / HiF personnel and medical personnel in Spain and France, and that to the best of your knowledge, this student is ready and able to study abroad.

**Name of Physician:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Thank you for your prompt completion of this important information.**