ciee

# Physician Medical Report Form

Name (please print) _____

Program _____

Signature: _____

Term(s) (*check all that apply*): ☐ Summer ☐ Fall ☐ Spring ☐ January/May **YEAR**_____

## To the Applicant

Please fill out your name, program and signature above and then give this form to your physician. Participation in the program is contingent upon CIEE International Study Programs staff receiving a completed medical report from you and your physician. Your doctor should complete this report based on an examination within four months of the program departure date.

*Note: It is our policy not to accept reports filled out by a parent-physician.*

## To the Physician

It is essential that your replies be based on a current and thorough physical examination and knowledge of the applicant's medical history. Any additional comments relevant to the patient's physical or psychological condition should be provided on a separate sheet signed and dated by you, the physician. IF YOU HAVE QUESTIONS ABOUT THIS FORM PLEASE CONTACT CIEE AT 1-800-407-8839.

1. How long have you known the applicant?
2. What is the date of the applicant's most current examination?
3. Are you:
   - ☐ Applicant's family physician
   - ☐ College physician
   - ☐ Other
4. What is the applicant's general state of health?
   - ☐ Excellent ☐ Good
   - ☐ Fair ☐ Poor
5. Please indicate the applicant's vital signs (at rest):
   a. Pulse Rate b. Skin c. Respiration d. Temperature e. Blood Pressure

**If the answer to any of the following questions is yes, please give details on a separate sheet. In each case please indicate whether the condition is likely to affect the student's full participation in the program.**

| | | YES | NO |
|---|---|---|---|
| 6. | Is the applicant significantly underweight or overweight? | ☐ | ☐ |
| 7. | Is the applicant currently taking any medications? | ☐ | ☐ |
| 8. | Is the applicant allergic to any form of medication? | ☐ | ☐ |
| 9. | Has the applicant received the following immunizations? If yes, please provide the date of last immunization. | ☐ | ☐ |
| | DATE | | |
| | a. Diphtheria, Pertussis, Tetanus (DPT) | ☐ | ☐ |
| | b. Mumps, Measles, Rubella (MMR) | ☐ | ☐ |
| | c. Polio (Oral or Injectable) | ☐ | ☐ |
| | d. Hepatitis A | ☐ | ☐ |
| | e. Hepatitis B | ☐ | ☐ |
| | f. Typhoid | ☐ | ☐ |
| | g. Other _____ | ☐ | ☐ |
| 10. | Has the applicant ever suffered from asthma or any other respiratory ailment? | ☐ | ☐ |
| 11. | Is the applicant currently under treatment or observation for any physical or emotional condition? | ☐ | ☐ |
| 12. | Does the applicant have any speech, hearing, or eyesight impairment that might affect participation in the program? | ☐ | ☐ |
| 13. | Has the applicant any physical disability that might cause hardship through change of diet, carrying luggage, or strenuous travel? | ☐ | ☐ |
| 14. | In your judgment will the applicant require assistance from an aide or other second party because of an existing condition at any time on the program? | ☐ | ☐ |
| 15. | Is there any congenital malformation now existing that may require additional treatment? If yes, what is this congenital condition and what treatment is to be pursued? (Please note that CIEE's insurance coverage does not include treatment of preexisting conditions.) | ☐ | ☐ |
| 16. | Does this person have a history of emotional disturbance? Has the applicant displayed any of the following? Please explain. | ☐ | ☐ |
| | a. difficulties in relations with parents, authority figures, peers | ☐ | ☐ |
| | b. behavior disorders | ☐ | ☐ |
| | c. symptoms such as eating disorders, mood swings, depression, severe sleep disorders, unusual degree of anxiety, fear, or guilt | ☐ | ☐ |
| 17. | To your knowledge, are there any predisposing medical, surgical, or emotional factors that may under stress or duress during the program present a need for immediate therapy while abroad? Please explain. | ☐ | ☐ |

**Any additional comments relevant to the patient's physical or psychological condition should be provided on a separate sheet signed and dated by you, the physician.**

Physician's Name _____ Physician's Signature _____ Date _____

Physician's Address _____ Physician's Phone Number _____