THE CITY COLLEGE OF NEW YORK, CUNY
STUDY ABROAD PROGRAM
PHYSICIAN'S STATEMENT

TO THE APPLICANT:
Please authorize by your signature below (page 2) the release of any medical information that may be relevant in the opinion of your physician to your participation in the study abroad program.

_____ _____
Applicant's Name **Program name and location**

Personal History – Please check if you have had:

___Tuberculosis ___Scarlet fever ___Measles ___Rubella ___Chicken pox ___Rheumatic fever

___Hepatitis ___Malaria ___Polio ___Other_____

Surgery

___Appendectomy ___Tonsillectomy

___Hernia repair ___Other_____

Habits (how much/how often)

___Alcohol_____

___Tobacco_____

___Other _____

Allergy (please specify)

___Hay fever ___Eczema ___Bees/wasps ___Pet/animal dander _____

___Foods_____

___Other _____

Review of Past Illnesses and Symptoms

Please complete the following, adding additional paper if necessary. **DO NOT LEAVE ANY QUESTION BLANK.**

A. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years for specific illness? (If yes, give details)
_____

B. Have you ever been hospitalized or had a serious acute illness? If yes, give diagnosis and date.
_____

C. Do you have any chronic/recurrent illness? Any permanent/chronic injury or physical disability? (If yes, give details.)

_____

D. Have you had any allergic reaction to past immunizations, prescription, or over-the-counter medicines? (If yes, give details.)

_____

E. Do you have a history of asthma or any other respiratory ailment? (If yes, give details.)

_____

F. Are you currently taking any medications (including oral contraceptives)? (List and give details.)

_____

G. Are you currently receiving antigen/immunotherapy injections or prescription medication for an allergy? (List and give details.)

_____

H. Do you have any health requirements or dietary restrictions? (Explain.)

_____

I. Do you have a history of an eating disorder, such as bulimia or anorexia, within the last five years? (If yes, give details.)

_____

J. In the last five years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional? (If yes, give details.)

_____

Please check if you have had:

___Unexplained fever ___Recent weight gain or loss ___Eye trouble ___Hearing loss ___Sinus problems

___Chronic rash ___Anemia ___Bleeding/clotting problems ___Cancer or leukemia ___Immune system problems

___Heart murmur, palpitations ___Chest pain, pressure ___Chronic cough ___Shortness of breath, wheezing

___Abdominal pain ___Chronic indigestion, diarrhea ___Stomach ulcer ___Gall bladder trouble ___Hernia (rupture)

___Kidney stone ___Albumin or blood in urine ___Painful/swollen joint ___Back problems ___Impaired use of any limbs

___Epilepsy (seizures) ___Recurrent dizziness or faintness ___Depression ___Severe headaches

Women only

___Irregular periods ___Severe cramps ___Excessive flow

Comment below on any condition(s) above that you have checked:

I certify that the information above is accurate and complete.

Signature **Date**

Applicant's Name **Program name and location**

TO THE PHYSICIAN:
Please indicate if the student named above has a history of chronic or disabling physical conditions; any allergies which may require either continuing or emergency treatment; any special dietary restrictions; or any physical or emotional condition which might affect his/her well-being or that of fellow students while living or traveling outside the United States.

Please indicate the student's blood type, as well as the generic names for any prescription medicine the student requires which may not be readily available abroad.

PLEASE NOTE: There should be a written statement from the Physician confirming that the student is physically and mentally sound enough to participate.

PHYSICIAN'S NAME: (Please print) _____

Address: _____

Phone Number: _____

Signature:_____ Date: _____

A DOCTOR'S STAMP OR LICENSE# IS REQUIRED