



PHYSICAL EXAMINATION FORM

Participant's Name _____ Date of Birth _____

The student listed above has been accepted to study abroad through Academic Studies Abroad for a summer, semester, or academic year program. In order for Academic Studies Abroad to provide the safest environment possible to all participants, it is imperative that we are aware of any physical or mental health issues that each participant may have.

Height in inches:

Weight in pounds:

1. Based on your examination of the participant listed above, do you believe he/she is in good physical and mental health and approve them to study abroad? Yes No
2. If you answered yes to question 1, are there any physical or mental health issues that may need to be addressed while the participant is abroad? Yes No
 - a. If you answered "yes", please give details:
3. Does the participant have any allergies to medications, foods, or animals? Yes No
 - a. If you answered "yes", please give details:
4. In case of emergency, is there any medical information about the participant that would be important for us to give to the attending physician? Yes No
 - a. If you answered "yes", please give details:
5. Is there any additional information about the participant that Academic Studies Abroad should be aware of? Yes No
 - a. If you answered "yes", please give details:

Signed this _____ day of _____, 20_____

Provider Name*

Signature

Provider's Address

**Please note that we can only accept forms signed by a Physician, Physician's Assistant, or Nurse Practitioner. We cannot accept forms signed by a parent of the participant, even if he/she is a Physician, Physician's Assistant, or Nurse Practitioner.*

Please return this form to:

**Academic Studies Abroad,
4 Belgrade Avenue, Suite 5
Roslindale, MA 02131
Toll-free (888) 845-4272 / Fax (617) 327-9390**