



River Plaza  
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Stamford, CT 06902-3788

AMERICAN INSTITUTE  
FOR FOREIGN STUDY  
PARTNERSHIP PROGRAMS

# MEDICAL EXAMINATION FORM PARTNERSHIP PROGRAMS

Participant \_\_\_\_\_

Program \_\_\_\_\_

Term \_\_\_\_\_

**Have this form completed by a licensed physician and return it to the above address at least two weeks prior to departure. The fee for this examination is not chargeable to AIFS; it should be collected by the physician from the participant. Exam must be conducted within the past six months.**

A. To the best of your knowledge and belief, has the participant ever had, been treated for, or told that she/he had:

- |   | <b>YES</b>               | <b>NO</b>                |
|---|--------------------------|--------------------------|
| 1. Heart disease, high blood pressure, varicose veins or disease of the circulatory system                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Diabetes, goiter or any disease of the glands  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Epilepsy, fainting attacks, or other disease of the brain or nervous system  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Fistula, fissure, hemorrhoids or other disease of the rectum   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Cancer or tumor, syphilis or tuberculosis  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Asthma, pleurisy, or other disease of the respiratory tract  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Neck or back strain or injury or hernia  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Any deformity or loss of limb  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Any disease of the reproductive organs   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Schizophrenia or any mental disorder  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Manic depression or depression  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Anorexia and/or bulimia   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ulcer or any disease of the stomach, intestines, liver, gall bladder or other disease of the gastrointestinal tract | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Sugar in urine, kidney disease, or other disease of the genitourinary tract   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Arthritis, rheumatism, or other disease of the bones  | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Any impairment of sight, speech or hearing, or any disease of the eye, ear, nose or throat                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Any surgical operation performed or been advised to have any performed during the past five years                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Any substance abuse   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Allergic reactions to food, environment or drugs  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Any special dietary needs, preferences or difficulties  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Any menstrual problems including irregular/painful periods and pre-menstrual syndrome                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Any other illnesses, diseases or treatments not mentioned above during the past three years                         | <input type="checkbox"/> | <input type="checkbox"/> |

Give details to all "yes" answers. If more space is needed, attach separate sheet

Question #	Name of condition	Date occurred	Duration	Degree of recovery	Names and addresses of physicians, hospitals or clinics consulted

Name: \_\_\_\_\_

Program: \_\_\_\_\_

B. Height \_\_\_\_ft. \_\_\_\_in. Weight \_\_\_\_\_ lbs. Blood pressure S\_\_\_\_\_ D\_\_\_\_\_ D\_\_\_\_\_

C. Is the applicant presently using any kind of medically prescribed medication?  yes  no

If yes, please list all medications (both prescription brand and generic name) applicant is currently taking and medical condition \_\_\_\_\_

D. When did the patient receive the Tetanus vaccine? \_\_\_\_\_

Until what date is the patient covered? \_\_\_\_\_

E. Are there any special needs that would either restrict the applicant from participating in essential functions of studying abroad or require accommodations in order to successfully participate in the program?  yes  no

If yes, please give details \_\_\_\_\_

**Please note:**

- If a doctor is unwilling/unable to prescribe in these quantities, students should plan ahead for a postal delivery or make other arrangements, but please be aware that in many European countries it is not possible to send prescription medications through the mail and packages will not be delivered.  
AIFS highly recommends that students take medical advice about the side effects that flying, temperature changes, different foods and alcohol may have on their reaction to medications.
- If a student has a disability that requires a special "accommodation" or special conditions, he/she should request information about the specific campus in advance. Some AIFS locations abroad may not have handicap access like that which is available and expected in the U.S.
- If a student does not submit a medical form prior to departure he/she will not be permitted to participate in the program.

I certify that the medical information supplied is both accurate and complete. I certify that the foregoing statements and answers are entirely true and complete and that no material has been withheld or omitted, concerning my past and present state of health. I agree that the answers are the basis on which the insurance applied for may be made effective.

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

I have today carefully examined and find said person in sound health and free from all physical defects and infirmities, except as stated.

Signature of physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_