**EXAMINATION DETAILS**

The physician MUST complete ALL items in this box for this form to be accepted as complete.

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Examination Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
</table>

**How long have you known the patient?**

---

**MEDICAL HISTORY/CURRENT CONDITION(S)**

The physician should check all that apply and provide details, if applicable, where requested.

- Allergies of any kind
- Anaphylactic Shock
- Asthma
- Cancer or tumors
- Chronic respiratory problems
- Chronic digestive/g.i. problems
- Colitis
- Diabetes
- Dizziness/fainting spells
- Eating Disorder
- Epilepsy or seizures
- Heart or circulatory complications
- Head injury
- High blood pressure
- Jaundice/hepatitis
- Liver or gall bladder problems
- Menstrual problems
- Narcotic/alcohol dependency
- Psychological/emotional/psychiatric conditions
- Reaction to antibiotics
- Recent gain of weight
- Recent loss of weight
- Skin disease
- Thyroid problems
- Trouble with ears, nose, or throat
- Tuberculosis
- Venereal disease
- Vision correction
- Other:

**ER TREATMENT/HOSPITALIZATION**

If the patient has ever been hospitalized or been treated in an emergency room, please provide treatment details here:

<table>
<thead>
<tr>
<th>Date(s)</th>
<th>Reason for/Nature of Treatment</th>
<th>Outcome/Present Condition</th>
</tr>
</thead>
</table>

Please attach an additional sheet if necessary.

**MEDICATION(S)**

If the patient is now taking any medication that he/she will be bringing with him/her on the IES study abroad program, please provide details of all medication.

Additionally, please discuss with patient means to obtain necessary supply of medicine while abroad.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Prescribed for</th>
<th>Dosage</th>
</tr>
</thead>
</table>

Please attach an additional sheet if necessary.

**SUMMARY & SIGNATURE**

Is there any medical condition that currently affects this patient and may require follow-up care while the patient is abroad?

- **YES**: Please explain
- **NO**

Is there any psychological condition that is currently affecting this patient and may require follow-up care while the patient is abroad?

- **YES**: Please explain
- **NO**

With my signature below, I acknowledge the patient is physically and mentally able to participate in a study abroad program.

**SIGN HERE**

Examiner’s Signature ___________________________ Date ________________

Examiner’s Name (please print) ___________________________ Title ________________

Examiner’s Address ________________________________

Examiner’s Telephone Number ________________________________

[Please return completed form by the due date to Off-Campus Study & Exchanges at Skidmore College.]