

CIAP Medical Report – Exchange and Study Abroad Students

Part I: Student Self Evaluation

Name _____ Program _____ Semester _____
Home College _____ CWID/SS# _____ Phone _____

TO BE COMPLETED BY THE STUDENT: Please complete and sign the front side of this form. You are responsible for coordinating with a physician, certified nurse practitioner or physician's assistant to COMPLETE THE BACKSIDE OF THE FORM after having a CURRENT exam, and return the ORIGINAL form to CIAP. No other medical forms will be accepted in substitution.

Sex ____M ____F

Are you required to wear a health emergency bracelet? ____YES ____NO If yes, for what condition? _____

Have you had or do you currently have any of the following conditions? Please mark all that apply, specifying the date, whether past or current. **If yes**, please detail information. Attach additional sheet if necessary.

Medical Condition	Past Date	Current	If yes, please detail information
1. Alcohol/Drug addiction	_____	_____	_____
2. Allergies	_____	_____	_____
3. Asthma	_____	_____	_____
4. Cancer	_____	_____	_____
5. Chronic Condition	_____	_____	_____
6. Diabetes	_____	_____	_____
7. Eating Disorder	_____	_____	_____
8. Epilepsy/Seizure Disorder	_____	_____	_____
9. Frequent Trouble Sleeping	_____	_____	_____
10. Heart Disease	_____	_____	_____
11. Painful shoulder, knee or back	_____	_____	_____
12. Thyroid Condition	_____	_____	_____
13. Other: _____	_____	_____	_____

Have you had any injuries, which have required hospital/ER attention? (i.e.: major accident, etc.) ____YES ____NO

If yes, **when** and for **what**? _____

Have you ever been hospitalized? ____YES ____NO If yes, **when** and for **what**? _____

Have you ever had any surgical procedures? ____YES ____NO If yes, **when** and for **what**? _____

What is your condition as a result of the surgery? _____

Are you currently taking any medication? ____YES ____NO If yes, **which medications** and for **what**? _____

Have you ever been treated for any psychological/emotional problem? ____YES ____NO If yes, **list dates**: _____

If yes, please describe the nature of the problem: _____

Did your treatment require medication? ____YES ____NO If yes, please **list medications**: _____

Current Status: _____

SPECIAL NEEDS: The following questions address disability-related needs for students. Provisions of the following information is voluntary.

Do you have a documented disability as defined by the Americans with Disabilities Act? ____YES ____NO

If yes, please state the nature of the disability _____

In which areas does your disability currently impair your ability to perform daily academic activities? _____

Are you requesting accommodations from CIAP for the above listed disability? ____YES ____NO

IF YES, SEPARATELY PLEASE PROVIDE DOCUMENTATION FROM A QUALIFIED PROFESSIONAL THAT SPEAKS TO YOUR CURRENT NEEDS FOR ACCOMMODATION.

***Receipt of the medical report after the deadline may result in delays with your housing placement and or having to find independent housing at your own expense.**

In signing this document, I verify that all of the medical and psychological information I have provided is accurate and complete, and I will notify CIAP hereafter of any relevant changes in my health that occur prior to the start of the program.

Student Signature _____

Date _____

Student is responsible for completing Part I and coordinating with the physician to complete Part II after a current exam. Return ORIGINAL form to: CIAP, 135 B.B. Comer Hall, Box 870254, Tuscaloosa, AL 35487-0254, Phone: (205) 348-5256

PLEASE TURN OVER FOR PART II; PHYSICAL EXAM ►

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Part II: Physical Exam

TO BE COMPLETED BY EXAMINING PHYSICIAN (MD or Certified Nurse Practitioner/Physician's Assistant only) ONLY after a CURRENT medical examination. No other medical forms will be accepted in substitution.

Patient's Name _____ Height _____ Weight _____ BP _____
Date of Examination _____ How long have you know the patient? _____

Please comment on the student's medical history by answering the following questions with Yes, No, or Not Applicable.

Has the patient:

had any past surgeries? ___ YES ___ NO ___ N/A
ever been hospitalized? ___ YES ___ NO ___ N/A
had Asthma? ___ YES ___ NO ___ N/A
had anaphylaxis reaction? ___ YES ___ NO ___ N/A

If yes, please provide details including dates

Please mark all conditions that currently apply:

<input type="checkbox"/> Allergies of any kind	<input type="checkbox"/> Jaundice/hepatitis
<input type="checkbox"/> Cancer or tumors	<input type="checkbox"/> Liver or gall bladder problems
<input type="checkbox"/> Chronic respiratory problems	<input type="checkbox"/> Menstrual problems
<input type="checkbox"/> Chronic digestive/g.i. problems	<input type="checkbox"/> Narcotic/alcohol dependency
<input type="checkbox"/> Colitis	<input type="checkbox"/> Psychological/psychiatric conditions
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Reactions to antibiotics
<input type="checkbox"/> Dizziness/fainting spells	<input type="checkbox"/> Recent gain of weight
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Recent loss of weight
<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Skin disease
<input type="checkbox"/> Frequent indigestion or ulcer	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Heart or circulatory complications	<input type="checkbox"/> Trouble with eyes, ears, nose, or throat
<input type="checkbox"/> Head injury	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Other: _____	

Please explain any items identified and attach additional sheet or Physician's report if necessary.

Is the student now taking any medication that they will be bringing with them on the CIAP overseas study program?
___ YES ___ NO If yes, please list all medication(s), dosage(s) and use(s):

Is there any historical medical condition (in particular those listed above) that has affected this student? ___ YES ___ NO
If yes, please comment:

Is there any historical psychological condition that has affected this student? ___ YES ___ NO If yes, please comment:

To the best of my knowledge, the above named student has no physical or mental conditions that should prevent him/her from participating successfully in the CIAP study abroad program he/she plans to attend.

Physician's Signature _____ Date _____

Physician's Name (Please Print) _____

Physician's Address _____

Physician's Telephone _____

Please return the ORIGINAL, completed form to:
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