ASSOCIATION OF ITALIAN AMERICAN EDUCATORS

MEDICAL REPORT FORM

Applicant (Type or Print)		
Program	Administering Campus	Location Abroad

Inquiries are made on a confidential basis.

Applicant's Birth Date_____

Program Country _____

TO THE EXAMINING PHYSICIAN: The above named student has been accepted to participate in the AIAE of New York overseas academic program. He/she will live and study for a summer, semester, or year in the country noted above. All are required to have immunizations recommended by the U.S. Public Health Service for the countries to be visited. This report should be based upon an examination made within six months of the expected overseas participation.

Please indicate your relationship with the student - note that we do not accept reports completed by a parent-physician:

_____Family Physician _____Other - Please describe_____

_____College Physician _____

Please indicate whether any of the following medical conditions exist, only if they could interfere substantially with the student's ability to successfully complete the overseas study program.

If the answer to any of the following questions is "Yes", please give details on the reverse side or a separate sheet.

1. Is the applicant seriously under or overweight?	_____ Yes	_____ No
2. Does the applicant have any physical disabilities which might cause hardship through change of diet, change of climate, carrying his own luggage, or strenuous travel?	_____ Yes	_____ No
3. Does the applicant have any dietary restrictions or food or other allergies?	_____ Yes	_____ No
4. Does the applicant have any speech, hearing, or visual impairment which might affect his participation in the program?	_____ Yes	_____ No
5. Does the applicant have any history of emotional disturbance?	_____ Yes	_____ No
6. Is there any existing health condition that may require treatment during the period of study abroad? If so what is the condition and what treatment may be required?	_____ Yes	_____ No
7. To your knowledge are there any predisposing medical, physical, or emotional factors.	_____ Yes	_____ No

If there is any additional information which would be helpful in deciding this student's ability to complete a study

Physician's Name	Signature
Address	Address

Please return this form directly to: