FIU | Office of Study Abroad
FLORIDA INTERNATIONAL UNIVERSITY

MEDICAL INFORMATION FORM INSTRUCTIONS

Please follow these instructions carefully.

Print this form and provide it to your medical provider. You **must** attach the study abroad brochure/official summary to your medical provider so that the provider can properly assess whether you can participate in the study abroad program for which you are applying.

This must be done within the due date established for the return of forms or your participation in the program will not be possible.

Once this form is completed you must scan it and upload it to your application on the Office of Study Abroad website: Abroad.FIU.EDU

If you have questions about this form and/or process, please contact the Office of Study Abroad at 305.348.1913.

Thank you.

Name of applicant:

_____

MEDICAL INFORMATION FORM
To be Completed by Physician Licensed in the United States

Name of Applicant: _____

Host Institution/Program Name: _____

Location of program: _____

Length of program: _____ Level of physical activity of program: _____

Age: _____ Height: _____ Weight: _____ Sex : ____ Male ___ Female

TO BE SIGNED BY THE APPLICANT

I hereby agree to the disclosure of information requested in this form to Florida International University. I further consent to the future disclosure of any and all medical information for the sole purpose of assessing medical needs or obtaining medical services by any medical facility in Florida or abroad, during the course of my study abroad program.

Signature: _____ Date: _____

PART I

Does the applicant now have or has she or he had any of the medical problems listed below (Please check appropriate box).

	YES	NO
a. Allergies to food or medications	☐	☐
b. Physical Handicaps	☐	☐
c. Psychiatric Disorders (including Eating Disorders)	☐	☐
d. Neurological Disorders	☐	☐
e. Cardiac Problem	☐	☐
f. Arthritis	☐	☐
g. Cancer	☐	☐
h. Diabetes	☐	☐
i. Glaucoma	☐	☐
j. Hypertension	☐	☐
k. Migraine Headaches	☐	☐
l. Renal Problems	☐	☐
m. T.B., asthma, or other Respiratory problems	☐	☐
n. Ulcers	☐	☐
o. Gynecological Problems	☐	☐
p. Learning Disability	☐	☐
q. Other	☐	☐

Name of applicant:

_____

If you have answered yes to any of the above, please explain in detail.

_____

_____

_____

_____

Please attach additional sheet if necessary.

PART II

1) Is the applicant currently receiving any medical treatment which would have to be continued while he /she is abroad? If yes, please describe its nature.

_____

_____

_____

2) Attached to this form is a brochure/summary of the activities that the student will be engaged in during the selected study abroad. In your judgment, is there any medical reason why this applicant cannot actively participate in the specific study abroad program described above?

_____

_____

_____

3) In my opinion the state of the applicant's health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date: _____ Signature: _____

Name (Print): _____

Position:_____

License Number: _____

Address: _____

Zip Code: _____ Phone _____