Greene Institute for
INTERNATIONAL
EDUCATION
BROWARD COLLEGE

PHYSICIAN'S STATEMENT

Student Name:______________________________________ Date of Birth:__________________________

Program and Country of Study:____

Dates of Study Abroad Program:____

To the Examining Physician:
The new and strenuous environment each student faces while participating in a Study Abroad Program will tax his/her physical and mental capabilities to the fullest. Therefore, it is imperative as a safeguard to the health of the participant, that this report be as complete and accurate as possible.

I. Please mark all *historic* or *current* physical or mental health conditions which apply:

_____ ADHD	_____ Depression	_____ Liver/Gall Bladder Problems
_____ Allergies of any kind*	_____ Diabetes	_____ Neurological Condition
_____ Anemia	_____ Dizziness/fainting spells	_____ Post-Traumatic Stress Disorder
_____ Anxiety Disorder	_____ Dyslexia	_____ Skin Disease/Disorder
_____ Asthma	_____ Epilepsy or seizures	_____ Thyroid Problems
_____ Cancer or tumors	_____ Head Injury	_____ Tuberculosis
_____ Chronic Respiratory Problems	_____ Hernia	_____ Other_____________________
_____ Colitis	_____ High Blood Pressure	

*If yes, please list allergies:____

II. Please indicate any operations, injuries, treatments sustained by/administered to the student:

OPERATION, INJURY, TREATMENT, ETC.	DATE(S) OF INCIDENT, TREATMENT, ETC. (Month/Year)

III. Please indicate any prescription medication the student may be taking:

MEDICATION NAME	DATE PRESCRIBED (Month/Year)

Updated 1/30/2018

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IV. Physician's release to participate:

I have examined ________________________________ *(student name) and believe that he/she is physically and emotionally qualified to participate in a study abroad program. He/she presents no evidence of communicable disease, of over-fatigue or any other physical or mental condition which would affect the quality of his/her academic performance or experience abroad.*

In my judgment, he/she is not likely to need medical or surgical attention during the proposed period of study abroad as the result of any treatment, disease, operation, or injury heretofore experienced.

Physician Name:________________________________ Date:____________________

Physician Signature:____

Address:____

Telephone Number:________________________ Fax Number:____________________

V. Student release of information:

I understand that this health information will be shared with the Greene International Education Institute and the onsite study abroad program coordinator. I acknowledge that my health information may also be shared with additional parties in the event of an emergency.

Student Signature:______________________________ Date:____________________

Parent/Legal Guardian Signature (If Student under Age 18):______________________

Please return completed form via mail or electronically to:

Office of International Education
Broward College-Weston Center
4205 Bonaventure Boulevard
Building 110/Suite 208
Weston, FL 33332
abroad@broward.edu
Tel. #: 954-201-7709
Fax #: 954-201-7708

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