FIU Office of Study Abroad
Florida International University

FLORIDA INTERNATIONAL UNIVERSITY
Office of Study Abroad (OSA)
MEDICAL INFORMATION FORM

Name of Applicant: _____

Host Institution/Program Name: _____

Age: _____ Height: _____ Weight: _____ Sex: M F

TO BE SIGNED BY THE APPLICANT

I hereby agree to the disclosure of information requested in this form and I waive my right to doctor-patient confidentiality in the event that Florida International University, and/or any medical facility in Florida or abroad requests my medical records during the course of my study abroad program.

Signature:_____ Date: _____

TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL:

PART 1:

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	☐	☐

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

_____

_____

_____

_____

Please attach additional sheet if necessary.

PART 2:

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) In your judgment, is there any medical reason why this applicant cannot actively participate in an extended (minimum one semester) exchange program abroad:

_____

_____

_____

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

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date: _____Signature: _____

Name (Print): _____

Position:_____

Address: _____

Zip:_____ Phone: _____