



**FLORIDA INTERNATIONAL UNIVERSITY**  
**OFFICE OF EDUCATION ABROAD (OEA)**  
**Medical Information Form**

Name of Applicant: \_\_\_\_\_

Host Institution/Program Name: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex : \_\_\_\_ Male \_\_\_\_ Female

**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 education abroad program.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL:**

**PART I**

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

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

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

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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.

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

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

Excellent       Good       Fair       Poor

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Name (Print): \_\_\_\_\_

Position: \_\_\_\_\_

Address: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone \_\_\_\_\_