JOHN JAY COLLEGE OF CRIMINAL JUSTICE, CUNY
OFFICE OF INTERNATIONAL STUDIES & PROGRAMS
PHYSICIAN'S STATEMENT

TO THE APPLICANT:
Please authorize by your signature below (page 2) the release of any medical information that may be relevant in the opinion of your physician to your participation in the study-abroad program.

__________________________ ________________________________
Applicant's Name **Program name and location**

Personal History – Please check if you have had the following (if not applicable, please indicate with N/A):

___Tuberculosis ___Scarlet fever ___Measles ___Rubella ___Chicken pox ___Rheumatic fever

___Hepatitis ___Malaria ___Polio ___Other____________________________

Surgery

___Appendectomy ___Tonsillectomy

___Hernia repair ___Other____________________

Habits (how much/how often)

___Alcohol___________________

___Tobacco___________________

___Other ____________________

Allergy (please specify)

___Hay fever ___Eczema ___Bees/wasps ___Pet/animal dander __________

___Foods____

___Other ____

Review of Past Illnesses and Symptoms

Please complete the following, adding additional paper if necessary. **DO NOT LEAVE ANY QUESTION BLANK. If not applicable, indicate with N/A.**

A. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years for specific illness? (If yes, give details)

____

B. Have you ever been hospitalized or had a serious acute illness? If yes, give diagnosis and date.

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C. Do you have any chronic/recurrent illness? Any permanent/chronic injury or physical disability? (If yes, give details.)

____

D. Have you had any allergic reaction to past immunizations, prescription, or over-the-counter medicines? (If yes, give details.)

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E. Do you have a history of asthma or any other respiratory ailment? (If yes, give details.)

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F. Are you currently taking any medications (including oral contraceptives)? (List and give details.)

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G. Are you currently receiving antigen/immunotherapy injections or prescription medication for an allergy? (List and give details.)

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H. Do you have any health requirements or dietary restrictions? (Explain.)

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I. Do you have a history of an eating disorder, such as bulimia or anorexia, within the last five years? (If yes, give details.)

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J. In the last five years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional? (If yes, give details.)

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Please check if you have had:

___Unexplained fever ____Recent weight gain or loss ____Eye trouble ____Hearing loss ____Sinus problems

___Chronic rash ____Anemia ____Bleeding/clotting problems ___Cancer or leukemia ____Immune system problems

___Heart murmur, palpitations ___Chest pain, pressure _____Chronic cough ____Shortness of breath, wheezing

___Abdominal pain ___Chronic indigestion, diarrhea ___Stomach ulcer ____Gall bladder trouble ____Hernia (rupture)

___Kidney stone ____Albumin or blood in urine ___Painful/swollen joint ___Back problems ____Impaired use of any limbs

___Epilepsy (seizures) _____Recurrent dizziness or faintness ___Depression _____Severe headaches

Women only:

___Irregular periods ___Severe cramps ____Excessive flow

Comment below on any condition(s) above that you have checked:

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With this signature, I certify that I have consulted with my physician and that I will follow through with all essential medications and care I may need to stay physically/mentally healthy and safe while abroad. Moreover, I certify that the information above is accurate and complete.

____________________________ ______________________

Participant Signature **Date** (MM/DD/YYYY)

____
Applicant's Name

____
Program name and location

TO THE PHYSICIAN:
Please indicate if the student named above has a history of chronic or disabling physical conditions; any allergies which may require either continuing or emergency treatment; any special dietary restrictions; or any physical or emotional condition which might affect his/her well-being or that of fellow students while living or traveling outside the United States.

Please indicate the student's <u>blood type</u>, as well as the generic names for <u>any</u> <u>prescription medication</u> the student requires which may not be readily available abroad.

Indicating a prescribed medication, especially one that is essential for the student's physical and/or mental wellbeing, will <u>require</u> the student to follow said prescription exactly as indicated by the physician while abroad. <u>Failure to do so will be grounds for dismissal from the program</u>.

PLEASE NOTE: There should be a <u>written statement</u> from the physician confirming that the student is physically and mentally sound enough to participate.

PHYSICIAN'S STATEMENT:____

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PHYSICIAN'S NAME: (Please print) ____

Address: ____

Phone Number: ____

Signature:____ **Date:** ________________________

A DOCTOR'S STAMP OR LICENSE NUMBER IS REQUIRED