RUTGERS
THE STATE UNIVERSITY OF NEW JERSEY

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Rutgers Summer in Paris Program

Physician Form

Please have your medical provider answer the following questions and sign and date below:

NAME: FIRST_____ LAST_____

This student is applying for the ***Rutgers Summer in Paris Program***. In the interest of the student's safe and successful participation, we would appreciate your cooperation in answering the following questions and adding any information that you feel is relevant to the student's ability to participate in the study abroad program. This information will remain confidential and will be provided only to the ***Rutgers Summer in Paris Program*** in New Brunswick, the on-site Program Director, and those with a need to know for the purpose of providing any necessary accommodations or in the event that medical attention is necessary.

State of General Health: ◯ Good ◯ Fair ◯ Poor

Age _____ Height _____ Weight _____

1. Does the applicant have any physical disability? ***yes*** ◯ ***no*** ◯

2. Has the applicant been treated for mental disorder or emotional disturbance within the last five years? ***yes*** ◯ ***no*** ◯

3. Does the applicant have any dietary restrictions or known allergies (e.g., food, medication, etc.) that the program should be aware of in the event of an emergency? ***yes*** ◯ ***no*** ◯

If yes, please describe below (including information about the severity of the allergy).

4. Is the student taking any medications, or will the student be taking any medications while abroad, that the program should be aware of in the event of an emergency? (Please note that the availability of medications varies by country and this should be researched before going abroad). ***yes*** ◯ ***no*** ◯

If yes, please list the medications and describe what they are used for.
(Please attach additional sheets if necessary)

5. Are all routine immunizations up to date? ***yes*** ◯ ***no*** ◯

6. Is the student currently being treated, or has the student been previously treated for any chronic or serious medical condition (e.g., diabetes, asthma, congenital disorder, cancer, eating disorder, psychiatric illness, etc.)?

If yes, please describe below and include any ongoing treatment that the student is receiving and may need to continue while abroad. (Please attach additional sheets if necessary.)

7. Have you any further medical data that should be known to the Director of the program? ***yes*** ◯ ***no*** ◯

8. Does the student require accommodations to a disability to enable her/him to participate in this program? ***yes*** ◯ ***no*** ◯

If yes, please describe below. (Please attach additional sheets if necessary)

Foreign travel and study abroad necessarily involve stress due to exposure to different cultural and physical environments, as well as the potential for possible experience with a medical and healthcare situation different from that found at home. Is there any additional information that would be helpful for the program to be aware of during this student's study abroad experience (please check the relevant box)?

☐ No medical contraindications were identified during this examination that precludes this student from participation in the study abroad program.

☐ No medical contraindications were identified during this examination that precludes this student from participation in the study abroad program. However, based on the student's disclosed history and today's physical exam, further evaluation through CAPS or an outside mental health/counselling provider is **required** to evaluate this student's ability to safely and successfully travel abroad.

Doctor's Name (print) _____ Date _____

Address _____

City _____ State _____ Zip _____

Signature _____ Phone: _____

Please mail, fax or email completed form to:

Department of French
Attention: Sarah Schroeder, Program Coordinator
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