COLBY COLLEGE
OFF-CAMPUS STUDY
WATERVILLE, ME 04901, USA
(+1) 207-872-3648

Confidential Physician's Report

(To be completed by College or University Health Service)

INDICATE PROGRAM TO WHICH YOU ARE APPLYING: _____

FOR STUDY DURING (CIRCLE ONE): FALL SEMESTER SPRING SEMESTER ACADEMIC YEAR

Name of Applicant_____

To the Examining Physician The applicant named above is applying for admittance to a program of study and travel abroad. Some health and counseling services may not be as available as at the student's home university. We request your careful and complete evaluation of this applicant's health. Furnish any medical information, physical and/or emotional, that could be of help to our resident director during the coming semester. *Please consider, in particular, the case of an unconscious student being treated in a hospital with this report constituting the sole medical history.*

This form has two sides. Both sides must be completed.

Date of Examination_____

Applicant's general state of health: Excellent Good Poor

Does the applicant have any dietary restrictions? Yes_____ No_____

Is the applicant allergic to any foods or drugs? Yes_____ No_____

Does the applicant need any special medication? Yes_____ No_____

Is there any history of physical disability or emotional disturbance that might present a problem in the semester abroad? Yes_____ No_____

Is the applicant presently receiving treatment for a physical or emotional condition?
Yes_____ No_____

Note: Student must fill out release of information form if he/she is using counseling services. This form may be obtained from the Off-Campus Study Office.

Is there any serious impairment of eyesight, hearing, or speech?
Yes_____ No_____

Date of last tetanus shot_____

(OVER) →

Please indicate below any additional medical information that could be of help, and fill out one of the two following boxes.

I have examined_____ and believe him or her to be physically qualified to participate effectively in a year's program of study and travel abroad.

Date_____ Name of Physician_____

Address & Phone No._____

Signature_____

OR

I have examined _____ and he/she is under treatment for _____.

He/she will require a letter from his/her treating practitioner before qualifying for study abroad.

Date_____ Name of Physician _____

Address and phone no. _____

Signature _____

Please use this space for your comments (attach additional letter if necessary)