Newcomb-Tulane College

Office of Study Abroad
Center for Global Education

PHYSICIAN'S STATEMENT
FOR STUDY ABROAD PARTICIPATION

Student Name	City/Country Program	Height	Weight
_____	_____	_____	_____

To the Examining Physician: The above named student has been accepted to participate in a Newcomb-Tulane Study Abroad Program and will live abroad for six months to a year in the country noted above. The information provided by you below will enable Office of Study Abroad to provide appropriate counseling and support services for a successful and rewarding experience.

1. Does the applicant have any physical disabilities which might be aggravated through a change of diet, change of climate, carrying his/her own luggage, or strenuous travel? **YES ☐ NO ☐** (If yes, please explain)

2. Does the applicant have any dietary restrictions? **YES ☐ NO ☐** (If yes, please explain)

3. Does the applicant have any allergies to food or other allergens? **YES ☐ NO ☐** (If yes, please explain)

4. Does the applicant have any history of emotional disturbance? **YES ☐ NO ☐** (If yes, please explain)

5. Are there any existing health conditions that may require treatment during the period of study abroad? **YES ☐ NO ☐** (If yes, please explain) If so, what are the condition(s) and what treatment(s) may be required?

6. To your knowledge, does the applicant have any predisposing medical, physical, or psychology factors which may require treatment while the student is abroad or that could be exacerbated by the stress of adjusting to another culture? **YES ☐ NO ☐** (If yes, please explain)

7. Do you know if this student is using any type of drug or medication for health reasons which may be difficult to acquire or may be illegal in their study abroad program country? **YES ☐ NO ☐** (If yes, please explain)

8. Is the applicant currently on any medication? **YES ☐ NO ☐** (If yes, please explain)

If you answered yes to any of the above questions please give details below or on back:

_____

_____

_____

_____

I have examined _____ on _____and certify that he/she is physically and
(Patient's Name) (Date of Examination)

mentally able to participate in a Newcomb-Tulane Study Abroad Program.

_____ _____

Signed Print Name

Date: _____

Address: _____

Telephone Number: _____ Email Address: _____