HEALTH / MEDICAL REPORT

HOOD COLLEGE

PHYSICIAN SECTION

Please provide this form to your doctor to fill out.

(*We cannot accept reports filled out by a parent physician.)*

_____ (student name) is planning to spend an academic semester traveling along the Mid-Atlantic Coast of the United States with Hood College's Coastal Studies Semester. The information you provide regarding the student's health will assist our office in anticipating and dealing with any health problems that may arise during her or his travel experience with us.

Please use this form to evaluate the physical and mental health of the student, adding any details not covered by the questionnaire. Your reply will be kept strictly confidential. Return the completed evaluation in the envelope provided by the student.

I am the students:	Family physician	◯	College physician	◯	Other	◯
Date of last Physical Exam			How Long have you know the student?			
Students general health is:	Excellent	◯	Good	◯	Poor	◯
Immunizations and dates received	Tetanus: Y◯N◯ Date:		MMR: Y◯N◯ Date:		Polio: Y◯N◯ Date:	

If the answer to any of the following question is "Yes", please give details on a separate sheet. In each case, please indicate whether the condition is likely to affect the student's full participation in the program.

	Yes	No
1. Is the student significantly underweight or overweight?	◯	◯
2. Is the student allergic to any form of medication? If yes, please specify:	◯	◯
3. Has the student ever suffered from asthma or any other respiratory ailment?	◯	◯
4. Is the student currently under treatment or observation for any physical or emotional condition?	◯	◯
5. Is there any history of eating disorders?	◯	◯
6. Does the student have any speech, hearing, or eyesight impairment that might affect participation in the program?	◯	◯
7. Does the student have any physical disability whose effects might be amplified with diet changes, carrying luggage, or strenuous travel?	◯	◯

8. Might the student require assistance from an aide or other second party at some time during the program due to an existing condition?	◯	◯
9. Is there any congenital malformation now existing that may require additional treatment?	◯	◯
10. Does the student have a history of emotional disturbance?	◯	◯
11. Has the student shown any:	◯	◯
a. difficulties in relations with authority figures or peers?	◯	◯
b. behavioral disorders?	◯	◯
c. symptoms such as mood swings, depression, severe sleep disorders, unusual degrees of anxiety, fear, or guilt?	◯	◯
12. To your knowledge, are there any predisposing medical, surgical or emotional factors that may, under stress or duress during the program, present a need for immediate treatment while traveling?	◯	◯
13. **Based on the physical and mental health of the student, should she or he, to the best of your knowledge, be able to complete a full semester program of study and residence while traveling?**	◯	◯

Physician's name:_____
Please print

Physician's signature:_____

Mailing address:_____
Number/Street/Post office box

_____
City or town State/Province or Country Zip or Postal code

Telephone: (_____)_____ Fax: (_____)_____

E-mail address:_____