



BELLARMINE
UNIVERSITY
IN VERITATIS AMORE

Bellarmine University Physician's Form for Study Abroad

Student's Name: _____ Date: _____

To Student: Please give this form to your physician. Return it to the Director of the Office for Study Abroad and International Learning (CNHH111), Bellarmine University, 2001 Newburg Rd, Louisville, KY, 40205. Your file will not be considered complete until it is received.

To Physician: This student has been accepted as a participant in an overseas study program through Bellarmine University. He/she will undertake a challenging academic program during the next semester. It is important that the student be in good physical and mental health.

Please check if you are:

Family physician _____

Other _____ (please describe) _____

Please indicate student's state of health:

Excellent ____ Good ____ Fair ____ Poor ____

If the answer to any of the following questions is "YES," please give details on the back of this sheet.

1. Does the applicant have any dietary restrictions or food allergies? Yes ____ No ____
2. Does the applicant have any other allergies? Yes ____ No ____
3. Does the applicant have any physical disabilities which might cause hardship through change of diet, carrying luggage, or strenuous travel? Yes ____ No ____
4. Is there any condition now existing that may require additional treatment? If the answer is yes, what is the condition and what treatment is to be pursued? Yes ____ No ____
5. To your knowledge, are there any existing medical, surgical, or emotional factors which may, under stress or duress, present a need for treatment while abroad?
Yes ____ No ____

Is there any other health information which is relevant to the student's plans for study abroad?

Physician's Name _____
(Please Print)

Signature: _____ Date _____

Address: _____

Telephone: (_____) _____