

PHYSICIAN'S CERTIFICATE

Georgia Southern University Study Abroad and Exchange Programs

PROGRAM TITLE or LOCATION: China + Vietnam Study Abroad Program

(To the student: Your physician should complete this form based on an examination in the last six months. The test to determine blood type is not specifically required by the Board of Regents, thus it is not necessary to perform the test. If your family doctor, parent or guardian can provide you with this particular information, please submit it below. For information on recommended shots and vaccinations for your destination, please see the Centers for Disease Control and Prevention website at <http://www.cdc.gov/travel/>).

Physical Examination

Date: _____

Name: _____ SS# _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Bloodtype (optional): _____

	Normal	Abnormal Findings	Initials
General Appearance	0	_____	_____
Heart (supine/standing)	0	_____	_____
Lungs	0	_____	_____
Pulses	0	_____	_____
Abdomen	0	_____	_____

Musculoskeletal

Neck	0	_____	_____
Shoulder	0	_____	_____
Elbow	0	_____	_____
Wrist	0	_____	_____
Hand	0	_____	_____
Back	0	_____	_____
Knee	0	_____	_____
Ankle	0	_____	_____
Foot	0	_____	_____
Other	0	_____	_____

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Please list the following:

- 1) Any medications which the student takes regularly: _____
 - 2) Any drugs/substances which the student is allergic to: _____
 - 3) Any chronic conditions or aspects of medical history which a foreign physician should be aware of in case of an emergency: _____
 - 4) Any special dietary requirements: _____
 - 5) Any limiting conditions which should be taken into account by the program director: _____
- _____

The program for which the student is applying may involve extensive walking in the summer heat, as well as adjustment to different time zones, food and water. In your professional judgment, will this applicant's physical condition hinder his/her full participation in such a program in any way?

Yes No

Please make any comments you deem pertinent to the applicant's ability to participate in the program.

Participation Status

Full Unlimited Participation

Limitations

Explain: _____

Participation with-held until

Explain: _____

Clinician's signature _____ Date _____
(Examining Clinician)

Student's Signature _____ Date _____

Please return to:
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