HEALTH EVALUATION – PART A

Participant and guardian signatures required.

Name _____ Sex (M/F) _____
Last First Middle

Date of Birth _____ / _____ / _____ Program _____

The purpose of this form is to help Accademia dell'Arte to be of maximum assistance to you should the need arise during your study abroad experience.

Mild physical or psychological disorders can become serious under the stresses of life while studying abroad. It is important that the program director be made aware of any medical or emotional problems, past or current, which might affect you in a foreign study context. The information provided will remain confidential and will be shared with the program staff, faculty, or appropriate professionals only if pertinent to your own well-being. Accademia dell'Arte may not be able to accommodate all individuals' needs or circumstances while studying abroad.

The information below does not affect your admission to the program.

MEDICAL HISTORY - PLEASE USE THE BACK OF THIS PAGE TO ELABORATE AS NEEDED

❑Yes ❑No 1. Are you generally in good physical condition? (If no, please explain).

❑Yes ❑No 2. Have you been treated for a psychological, psychiatric, substance abuse, or personal problem? (If yes, please explain).

❑Yes ❑No 3. Do you have any allergies? (If yes, please explain).

❑Yes ❑No 4. Are you taking any medications? (If yes, please list and explain for what condition).

❑Yes ❑No 5. Have you had any major injuries, surgeries, diseases, conditions or ailments in the past five years that would adversely affect your participation in the program? (If yes, please explain).

❑Yes ❑No 6. Are you a vegetarian or have special dietary needs? (If yes, please explain).

❑Yes ❑No 7. Have you ever studied, traveled or lived abroad? (If yes, please include information regarding the nature of your travel and whether you consider it to have been a positive experience.)

❑Yes ❑No 8. Is there any additional medical and/or psychological information that program faculty should be aware of during your study abroad experience? (If yes, please explain.)

IMPORTANT: *Accademia dell'Arte also wishes to inform students participating in our programs that it is not possible to have access to the type of mental/physical health assistance available in the US. In our admissions process, we do not discriminate against individuals with disabilities. However, for your own welfare, we ask that if you have any problems that could affect your participation in the program you should consult with your doctor and a mental health professional before you leave to discuss the potential stress or other adverse consequences of study abroad. Again, please be reminded that certain outpatient treatments like physical therapy and mental health treatment is not as widely accessible in many foreign countries as it is in the United States. For more information about this, please contact Monica Capacci, Director of Student Services, at monica@dellarte.it.*

I certify that all responses made on this form are true and accurate, and complete to the best of my knowledge. I will notify Accademia dell'Arte hereafter of any relevant changes in my health that occur prior to the start of the program.

Student Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

HEALTH INSURANCE INFORMATION

Health Insurance (American or Traveler's) is required for all students while attending this program.

Insurance Carrier _____

Company Name _____

Guarantor's Name _____
Last First Middle

Guarantor's Date of Birth _____ / _____ / _____

Guarantor's Employer _____

Please remember to provide a copy of your insurance card, front and back.

HEALTH EVALUATION – PART B

This section must be filled out by your doctor, nurse practitioner or school health center.

❑ I support and recommend the applicant for participation in the Accademia dell'Arte program in Italy. ❑ The applicant's physical and psychological status demonstrates the maturity necessary for overseas study.
❑ The applicant is in overall good health and can participate in a program of this nature without reservation.
❑ You have my permission and my client's permission to contact me with questions regarding his/her health.
❑ This student requires prescriptions to be filled while abroad. I have provided him/her with the generic prescription and the chemical breakdown of the medication in order to assist in having the prescription filled in Italy, if possible.
PLEASE NOTE: This does not guarantee that the prescription can be filled in Italy. If the student requires medication, or refills of medication, it is the responsibility of the student to make the appropriate contacts in order to ensure that he/she will have access to necessary medications and the necessary amount while abroad.
❑ I have performed a complete physical on the applicant on the date of _____ (must be within one year) that proved the applicant to be in overall good health.

Please fill out the following health evaluation information:

Name of Health Practitioner _____

Signature _____ Date _____

Address _____

Street City State Postal Code

Telephone (_____) _____ Fax (_____) _____

E-mail _____

Overall Remarks _____

_____

_____

PHYSICAL EXAM (CONTINUED): TO BE FILLED OUT BY DOCTOR

Student Name _____ Sex (M/F) _____
Last First Middle

Date of Birth _____ / _____ / _____

Height (inches) _____ Weight (lbs) _____ Pulse _____ Blood Pressure _____ Date of

Has the applicant received a Covid-19 vaccine? ❑ YES ❑ NO

If you answered no please explain why _____

Please check if:	**Normal**	**Abnormal** (If abnormal, describe fully)
Head, eyes, ears, nose, or throat	❑	❑
Neck	❑	❑
Respiratory	❑	❑
Cardiovascular	❑	❑
Genitourinary	❑	❑
Gastrointestinal	❑	❑
Musculoskeletal	❑	❑
Metabolic/Endocrine	❑	❑
Neuropsychiatric	❑	❑
Skin	❑	❑

PHYSICAL EXAM (CONTINUED): TO BE FILLED OUT BY DOCTOR

A. Please list all pertinent issues, conditions, etc. obtained from the student's medical history and physical examination.

_____

_____

_____

B. Recommendation for physical activity: ❑Unlimited ❑Limited Explain:

C. Do you have any recommendations regarding the care of the student? ❑ Yes ❑ No Explain:

D. Is the student now under treatment for any medical condition? ❑ Yes ❑ No Explain:

E. Current medications and dosages:

F. Has the student ever had treatment or counseling for an emotional, behavioral, or psychological condition (including eating disorders and/or substance abuse)? ❑ Yes ❑ No Explain:

If the answer is yes to D and/or F, a full medical report from the physician, psychiatrist, certified therapist, or counselor is requested. (A full report will include a statement of the problem [diagnosis], treatment, response to treatment, and need for follow-up.) This report should be directed to Accademia dell'Arte. This report will not be released without the written consent of the student.

Physician's Signature _____ Date_____