THE AMERICAN COLLEGE OF THESSALONIKI
MEDICAL EVALUATION

The information provided in this form will be kept strictly confidential. Students will not be allowed to register unless they submit and complete this medical evaluation with their application for admission.

Applicant Name: ______________________________________ Date of Birth: ________________

TO THE EXAMINING PHYSICIAN: Please indicate whether any of the following medical conditions exist, only if they could interfere substantially with the student's ability to successfully complete their study abroad semester/year at ACT. **If the answer to any of the following questions is "yes", please give details in the space provided or on a separate sheet.**

The new and sometimes strenuous environment each candidate will face taxes his/her physical and mental capabilities to the fullest. Therefore, it is imperative, as a safeguard to the health of the participant, that this form be as complete and accurate as possible.

Hemoglobin: ____________________ Blood Type: __________________ RH: _________________
VDRL: ___________________________ Urine: ______________ Albumin: ___________________
Vision: Right ________ Left ________ Hearing: Right ________ Left ________
Corrected to: Corrected to:
Height: ___________________________ Weight: __________________________

	Normal	Abnormal	Describe Every Abnormality
Head			
General Build			
Neck			
Ears			
Eyes			
Mouth, Throat			
Chest, Lungs			
Heart			
Vascular System-B.P.			
Hernia			
Abdomen & Viscera			
G. I. System			
G. U. System			
Upper Extremities			
Lower Extremities			
Spine			
Skin, Lymphatics			
Nervous System			
Mental, Psychological State			

Physical Activity: Full participation? ______________ Restrictions? _____________
____

Special Diet Required? ____

IMMUNIZATION: Month/Year	IMMUNIZATION: Month/Year	IMMUNIZATION: Month/Year
Hepatitus	Cholera	Tetanus
Malaria	Small Pox	Typhoid
Japanese Encephalitis	Yellow Fever	Diptheria

1. Does the applicant have any physical disabilities which might cause hardship through change of diet, change of climate, carrying his/her own luggage or strenuous travel? Yes ___ No ___
   ____

2. Does the applicant have any dietary restrictions or food or other allergies? Yes ___ No ___
   ____

3. Is the applicant receiving any medication? If so, please attach statement of such medication with dosage and directions for the counselor of the program to keep on file. Yes ___ No ___
   ____

4. To your knowledge, has the applicant ever used drugs? To what extent? Yes ___ No ___
   ____

5. Bearing in mind the various conditions imposed by a foreign study program, (lengthy absence from home, adjustment to a foreign culture, changed living/social conditions) will you please give us your evaluation of the applicant's emotional stability: ______________________________

6. If, to your knowledge, the applicant has been treated by a psychiatrist or psychologist, will you please so indicate? Yes ___ No ___
   ____

7. Is there any additional information that would be helpful to us? (Please use additional, separate sheets if necessary) Yes ___ No ___

   Summary of Defects/Recommendations: ____
   ____
   ____

PHYSICIAN'S STATEMENT:
I have examined ________________________________ and do/do not consider him/her physically qualified to participate in the American College of Thessaloniki Study Abroad program.

I certify that the above-mentioned statements made by me, in answer to foregoing questions, are true and complete to the best of my knowledge and belief. I understand that the American College of Thessaloniki will rely on my statements of fact.

Physician's Signature: _______________________________________ **Date:** __________________

Physician's Name (printed): ____
Telephone Number: _____________________________ Fax Number: __________________________
Address: ____
City: _______________________________________ State: __________ Zip: ____________________