

TRINITY COLLEGE OF ARTS AND SCIENCES, DUKE UNIVERSITY
DUKE STUDY IN CHINA PROGRAM

Form 2

PHYSICIAN'S REPORT

TO THE STUDENT:

Please print or type your name and address below before your physician or a physician at Student Health Services completes this report based on the medical examination. Please ask the doctor to complete the form promptly and mail or fax it without delay to:

Duke Study in China Program
323A Trent Drive Hall - Box 90411
Duke University
Durham, NC 27708-0411
Fax: 919-681-6247

Name of student: _____

Address _____

NOTE: It is suggested that you take with you to China written prescriptions for any medicines you need and also for glasses or contact lenses.

TO THE PHYSICIAN:

You are being asked to evaluate the physical and mental health of the above-named person for a Duke University Study Abroad Program. Participants in the Program will spend an academic summer and/or spring semester, engaged in intense study at the university level.

A study abroad program can create physical and emotional stress for those not able to adjust to the demands of living in a different physical and cultural environment for extended periods of time. It is important that participants have good physical health, stamina, and emotional maturity, as well as academic ability. We request, therefore, your frank evaluation. Please feel free to add any additional details not covered by the questions below.

Please check if you are:

_____ Family physician _____ College physician _____ Other (Describe)

The general state of health of the student is:

Excellent _____ Good _____ Fair _____ Poor _____

Student's Date of birth: _____ Height: _____ Weight: _____ Sex: _____

Date of examination upon which this report is based: _____

Physician's Form Page Two

Student Name: _____

If the answer to any of the following questions is yes, please provide details on a separate sheet:

- | | <u>Yes</u> | <u>No</u> |
|--|------------|-----------|
| 1. Is the student seriously underweight or overweight? | | |
| 2. Does the student have any dietary restriction or food allergies? | | |
| 3. Does the student have any physical disabilities which might cause hardship through a change of diet or climate, having to carry luggage, or strenuous travel? | | |
| 4. Does the student have any speech, hearing, or eyesight impairment which might affect participation in the program? | | |
| 5. Is there any medical problem now existing that may require additional treatment? If " <u>yes</u> ", what is this medical problem and what treatment is to be pursued? | | |
| 6. To your knowledge, are there predisposing medical, surgical, or emotional factors which may, under stress or duress during the program, present a need for immediate therapy while participating in the program? If " <u>yes</u> ", please explain below. | | |

7. If the student takes any medicines regularly or occasionally, please list:

<u>Name</u>	<u>Dose</u>	<u>Diagnosis</u>
_____	_____	_____
_____	_____	_____

If there is any other information which might be helpful to us, please use the space below.

Physician's Name _____ **Signature** _____

Address _____ **Telephone** _____

_____ **Date** _____