PLYMOUTH STATE UNIVERSITY- Global Education Office-Limerick
Medical Evaluation

IMPORTANT: To the Student Planning to Participate on a PSU Study Abroad Program

It is extremely important that you disclose all of your medical history to the medical professional who will be performing your medical evaluation, even if you do not believe that your condition might create a problem for you while you are abroad. Individuals with known and ongoing medical problems must take special precautions in preparing for and managing their situation overseas. The Global Education Office requires this Medical Evaluation in order to provide appropriate assistance to you should the need arise before or during your experience. This information will be kept confidential in accordance with the law. This information may be disclosed with your program contacts and with the highest level of discretion in order to protect your privacy.

Last Name:_____**First**:_____ **Male**:_____ **Female**:_____

Program/Country: **Limerick, Ireland** **Dates of Program**: **09/01/2014-12/20/14**

I agree to make true and accurate statements regarding my health to the examining Physician/Health Practitioner:

Student Signature:_____ **Date:**_____

STUDENT: DO NOT WRITE BELOW THIS LINE

IMPORTANT: To the Physician/Health Practitioner Conducting the Medical Evaluation

****Physician/Health Practitioner must be licensed in the U.S. and cannot be an immediate family member***

The person named above has been selected to participate in a Plymouth State University International Program. Depending on the program, the student may spend a month to one full year abroad. Living and studying in a foreign environment frequently creates unexpected physical and emotional stress, which can exacerbate otherwise mild disorders. It is important that all participants are able to adjust to potentially dramatic changes in climate, diet, and living and traveling conditions that may be seriously disruptive to accustomed patterns of behavior. Studying abroad does not provide a resolution to health problems experienced at home.

Yes ☐ No ☐	1. Does the student have any recent continuing health problems? (If yes, please explain)
Yes ☐ No ☐	2. Does the student have any existing health conditions that may require treatment during the period of the program? (If yes, explain the condition and what treatment may be required)
Yes ☐ No ☐	3. Is the student currently being treated or have they been treated within the past five years for a mental health condition? (If yes, please explain)
Yes ☐ No ☐	4. Does the student have any drug or food allergies? (If yes, please describe reaction)
Yes ☐ No ☐	5. Is the student taking any prescription medications? (If yes, please explain)
Yes ☐ No ☐	6. Is there any additional information that would be helpful for the program to be aware of? (If yes, please explain)
Yes ☐ No ☐	7. Does the student have any conditions that will require accommodations while on this program? (If yes, please explain)

PHYSICIAN/HEALTH PRACTITIONER: PLEASE PRINT CLEARLY

Name & Title:_____ **Phone Number**:_____

Address:_____

I have completed this medical evaluation based upon information disclosed by the student named above:

Signature of Physician/Health Practitioner:_____ **Date:**_____

Submit this form to:

Plymouth State University: The Global Education Office
MSC 44, 17 High St., Plymouth, NH 03264, Tel: 603-535-2336, Fax: 603-535-2528