

**PHYSICIAN STATEMENT**

Program: \_\_\_\_\_

Country: \_\_\_\_\_

Beginning Date: \_\_\_\_\_

Ending Date: \_\_\_\_\_

**This document and its contents constitute a student record and are exempt from public records under §1002.22 and §1006.52, Florida Statutes. The contents of this document can only be disclosed in accordance with the Student's and/or Parent(s)/Guardians consent.**

I have examined \_\_\_\_\_ and believe that he/she is physically fit and medically qualified to participate in an overseas study program. He/She presents no evidence of communicable diseases or over-fatigue or any other medical condition that would affect the quality of his/her academic performance or pose a medical danger to himself/herself or others while studying abroad.

His/Her personal health records are as follows: (Physician please take into consideration evidence of instability, headaches, allergy, insomnia, diabetes, depression, asthma, etc.)

DISEASE, OPERATION, INJURY

PERIODS OF DISABILITY

\_\_\_\_\_ from \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_

ADDITIONAL COMMENTS:

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In my judgment, the candidate is not likely to need medical or surgical attention during the proposed period of study abroad as the result of disease, operation or injury heretofore experienced.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Name (please print) \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone: \_\_\_\_\_

**CONSENT TO LIMITED DISCLOSURE:**

I hereby consent to Miami Dade College disclosing this information for the sole purpose of assessing my/student's medical needs or obtaining medical services on my/student's behalf.

\_\_\_\_\_  
Student's Signature Date

Required for students under 18 years of age:

\_\_\_\_\_  
Parent(s)/Guardian's Signature Date

\_\_\_\_\_  
Parent(s)/Guardian's Signature Date