**Rider University** **Healthcare Provider's Release Statement**
**Overseas Academic Programs**

TO THE STUDENT: By signing below you authorize the release of any medical information that may be relevant in the opinion of your physician to your participation in a study abroad program

Name: _____
Last First

Student Signature: _____
Date

Parent Signature: _____
(Required IF student is under 18 years of age)

**Program:**
Location Abroad: _____
Length of Overseas Program: _____
Dates of Participation: _____
**Program Organizer** (i.e. CAPA, ISA, Exchange…):
_____

**TO THE EXAMINING PRACTITIONER:** The above named student has been accepted to participate in a Rider University Overseas Academic Program. S/he will study abroad with Rider University. This report should be based upon an examination made within six months of the expected overseas program participation. Please review with the student the Health Disclosure Information form s/he completed. Please describe below any additional information that would help to further explain and/or clarify the student's self-reported health information. Review and update routine vaccinations as you deem necessary.

1) Please indicate your relationship with the student. (Note: Parent-physician reports are not acceptable.)
□ Family Healthcare Provider □ College/University Healthcare Provider
□ Other (describe): _____

2) Based upon your physical examination of this student, please explain your findings and recommendations.
**Physical Findings:**

**Recommendations:**

3) Is the student allergic to any medications? If so, please list:

4) Is there any existing health condition that may require treatment during the period of study abroad? If so, what is the condition and what treatment may be required?

5) To your knowledge are there any predisposing medical, physical, or emotional factors which under stress of adjusting to another culture may require treatment while the student is abroad? If so, please specify.

PRACTITIONER'S COMMENTS:

_____ Cleared based on information provided/physical _____ Not cleared at this time
_____ Discussed routine immunizations for travel per the CDC
_____ Discussed recommended region specific immunizations for travel per the CDC (if applicable)
_____ Discussed tuberculosis risk and recommended follow up (if applicable)
_____ Discussed risks associated with use of BCP's/tobacco (if applicable)

Additional recommendation/Comments: _____
_____

Healthcare provider's Name (please print): _____

Address: _____

Signature: _____Date:_____