



APPLICATION FOR INTERNATIONAL STUDENTS MEDICAL INFORMATION FORM

Name of Applicant: _____

Home Institution: _____

Age: _____ Height: _____ Weight: _____ Sex: Male Female

TO BE SIGNED BY THE APPLICANT

I hereby waive my right to patient-doctor confidentiality in the event that Espiritu Santo University, and / or any medical facility in Ecuador requests my medical records.

Signature: _____ Date: _____

TO BE COMPLETED BY A PHYSICIAN

PART I

Does the applicant now have or has he/she had any of the medical conditions listed below?
(Please check appropriate box).

YES NO

- a. Allergies to food or medications
- b. Physical Handicaps
- c. Psychiatric Disorders (including eating disorders)
- d. Neurological Disorders
- e. Cardiac Problems
- f. Arthritis
- g. Cancer
- h. Diabetes
- i. Glaucoma
- j. Hypertension
- k. Migraine Headaches
- l. Renal Problems
- m. T.B., Asthma, or other Respiratory Problems
- n. Ulcers
- o. Gynecological Problems
- p. Learning Disability
- q. Special Dietary needs

- r. Others

If you have answered yes to any of the above questions, please explain in detail.

Please attach another sheet if necessary.

PART II

1. Has the applicant tested positive for AIDS virus (HTVL III Antibody)?

Yes No

1. Is the applicant currently receiving any medical treatment, which would have to be continued while he / she is abroad? If yes, please describe its nature.

3. In your judgment, is there any medical reason why this applicant cannot actively participate in an extended (minimum four months) exchange program in Ecuador?

4. In my opinion, the state of the applicant's health is:

Excellent Good Fair Poor

Date: _____ Signature: _____

Name: _____

Position: _____

Address: _____

Phone: _____