The EXPERIMENT in International Living

1 Kipling Road, PO Box 676
Brattleboro, Vermont 05302
P: 800.345.2929
F: 802.258.3427

1015 15th Street NW, 9th Floor
Washington, DC 20005
P: 202.408.5420
F: 202.408.5397

info@experiment.org
experiment.org

PART IIIA

Experimenter Name: _____

Experimenter DOB: _____

Program Name: _____

Part IIIA: Further Health Information: Medical

To the Appropriate Healthcare Professional:
Studying abroad is an enriching experience as well as a physically, mentally, and emotionally challenging one. Mild or resolved (pre-existing) health conditions may become serious or recur for some Experimenters as they transition into unfamiliar cultures and environments. For this reason, we require all Experimenters to fully disclose their health history so we can help them prepare for their experience, make arrangements for any special accommodations if necessary, and—in some cases—assess whether health considerations pose great enough risk that an Experimenter should consider another program. Failure to disclose complete and accurate information on these health forms or failure to inform The Experiment of any changes in health history or status that occur after the submission of these health forms may result in an inability to meet accommodation requests or in dismissal from the program.

To support this Experimenter's health and wellness, we expect complete disclosure of any health history &/or concerns that could be experienced (problematic) overseas. Please give as much detail as possible in answering the following questions.

1. Review student-reported medical information (Part I) and verify completeness & accuracy.
2. Provide a detailed summary of medical issues for which you provide care for the student. You may also include a consultation summary.
3. Recommend for or against participation.

This information is strictly for the use of World Learning and The Experiment in International Living and will not be released without the applicant's consent.

The forms may be emailed by the Experimenter or your office to medicalteam@experiment.org.

Diagnosis:

_____

_____

Recent History of Illness:

_____

_____

Ongoing treatment that is anticipated to continue during the program:

_____

_____

Risk of this condition needing **additional** care during program: ☐ High ☐ Medium ☐ Low

What might this care consist of?

_____

_____

List any limitations, reservations, or other comments, to include recommendations if condition worsens:

_____

_____

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Licensed Medical Professional's Recommendation

Please check one of the following:

- ☐ **Experimenter is able to participate fully with no reservations.**
- ☐ **Experimenter may be able to participate, but with some difficulty or caveats.**
  (Please ensure your concerns, including specific reasons, are detailed in the summary above)
- ☐ **Participation is not recommended.**
  (Please ensure your concerns, including specific reasons, are detailed in the summary above)
- ☐ **Having received permission from said Experimenter, I am willing to further discuss problems pertaining to this issue with the professional staff of The Experiment.**

Provider Information

Thank you for providing a clear, honest, & concise assessment of this Experimenter's health status.

Physician's or health care provider's signature_____ Date _____
month/day/year

Name of practice_____ Phone_____
Include area code/country & city codes

Printed name_____ Email_____