# Study Abroad Physical Form

**Name:**

<table>
<thead>
<tr>
<th>PHYSICAL EXAM</th>
<th>Program:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Height _____</td>
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<td>Weight _____</td>
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<td>Temp _______</td>
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<tr>
<td>BP: R___/___</td>
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<td>L___/___ P____</td>
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<tr>
<td>RR____</td>
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<td>Vision: (R) 20/____</td>
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<td>(L) 20/____</td>
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<td>(B) 20/____</td>
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**LAB**

- (check if ordered)

- □ Serum Cholesterol/HDL ratio
  (once between ages 12 & 20)

- □ HCT or CBC
  (once between ages 12 & 20)

- □ Pap smear

- □ HIV

- □ Other __________

**IMMUNIZATIONS** Current? Yes □ No □

- □ Flu
- □ Hep B
- □ Tdap
- □ Hep A
- □ IPV
- □ MMR Booster
- □ PPD
- □ Menactra
- □ Other __________

- □ Other: specify

**TOPICS DISCUSSED**

- □ Alcohol
- □ Contraception
- □ Eating habits
- □ Marijuana
- □ Stress
- □ Allergies
- □ Copy passport/etc
- □ Environment
- □ Meds-Rx/OTC
- □ Social support
- □ Body image
- □ Dental care
- □ Exercise
- □ Record release
- □ Sunscreen/skin cancer
- □ CDC Travel
- □ Depression
- □ Food/water safety
- □ Seatbelts/traffic safety
- □ Depression
- □ Health site
- □ Diet issues
- □ Insurance issues
- □ Sexual health/STD

**ASSESSMENT**

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<tr>
<th>PROVIDER</th>
<th>PLAN</th>
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**ASSIST & PLAN**

Provider Signature: ___________________________ Date: ____________

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