THE SCHOOL FOR FIELD STUDIES

Physical Examination and Authorization Form

Participant Name _____

Program Location and Session _____

PART I: AUTHORIZATION: *- to be completed by Participant (if 18 or older) or by a parent/guardian (if under 18)*

My signature below indicates: 1) I have read and understand the Program Information for Participants and Medical Professionals below, and 2) I have provided honest, accurate, and complete information to the best of my knowledge and ability to the person conducting this examination and to The School for Field Studies, Inc; and 3) I have discussed, or will discuss, the immunizations and chemo-prophylaxis recommended by the Centers for Disease Control and Prevention for this program with a Travel Medicine Specialist or with my physician and will have them completed by the time the course begins; and 4) My health insurance policy is valid overseas and will remain in full force and effect for the duration of the SFS program that I will attend.

By my signature below, I hereby specifically authorize my physician, _____("Medical Provider"), of _____ (City, State) to release confidential patient information and/or medical records pertaining to myself, _____ ("Participant") to The School for Field Studies, Inc. ("SFS"), or its representative, to the extent necessary for the Medical Provider to complete the foregoing form and to assess the appropriateness of SFS for the Participant at this time. Furthermore, I hereby expressly authorize the Medical Provider to release such additional information as the Medical Provider deems necessary or appropriate to respond to any additional questions SFS may have regarding whether SFS is appropriate for the Participant based on the release of information authorized by this form. I also give SFS permission to discuss this medical information with a medical consultant designated by SFS. I recognize that this information may be protected by state and federal regulations, and that I am hereby waiving such rights. I understand that I may revoke this authorization at any time (except retroactively), and, in any event, this authorization will expire automatically one year from the date signed.

By my signature below, I hereby authorize the personnel of SFS to give first aid to Participant in the event that Participant is injured. I understand that SFS shall make every effort to obtain prior authorization (if Participant is under 18 or unable to give authorization) for any required medical or dental treatment from the parent/guardian or individual listed on this form as the Participant's Emergency Contact. In the event that prior authorization cannot be obtained, I authorize the personnel of SFS to exercise their prudent judgment in engaging physicians to provide diagnosis and treatment; in admitting the Participant to any hospital; and in giving permission for such diagnosis, treatment, and admission on the Participant's behalf as may be required. I agree that all costs of such services shall be charged to and paid for by the Participant or their parent/guardian.

X _____

Participant Signature AND (if under 18) Parent/Guardian Signature

Date _____ Date _____

Participant *Parent/Guardian*

PROGRAM INFORMATION for PARTICIPANTS and MEDICAL PROFESSIONALS

Participants attending The School for Field Studies, Inc. (SFS) engage in rigorous academic programs while based at SFS's international field stations. These centers are rustic and remote. Because of their remoteness, and because programs often take place in developing countries, transportation to modern medical care is sometimes difficult and may take as long as 24 hours. Mental health counseling and other specialty medical services are not readily available.

SFS programs involve physically and often emotionally, rigorous conditions. There is limited personal time and personal space. The challenges participants may expect to experience include group living, academic deadlines, extreme climates, heat, sun, biting and stinging insects, swimming, strenuous physical activity, hiking, and field work in rugged terrain. Exposure to tropical and regional illnesses such as malaria, dengue, leishmaniasis, giardia, and others are possible. Prior physical conditioning is recommended, and a flexible and enthusiastic attitude is a necessity.

THE SCHOOL FOR FIELD STUDIES

PART II: PHYSICAL EXAM: *- to be completed by an M.D., D.O., P.A., or R.N.P. who is not related to Participant*

Height (inches):_____ Weight (pounds): _____ Blood Pressure: _____ Pulse: _____

Please note any abnormalities in the areas listed below. If the exam is normal, indicate so by circling **YES**. If there are any significant problems relating to these areas, please explain each problem in the space provided below and note if the problem is current or inactive.

1. Head, Eyes, Ears, Nose and Throat Normal **YES NO**	*7. Gastrointestinal* Normal **YES NO**
2. Cardiovascular Normal **YES NO**	*8. Genitourinary* Normal **YES NO**
3. Respiratory Normal **YES NO**	*9. Skin* Normal **YES NO**
4. Musculoskeletal Normal **YES NO**	*10. Immune System* Normal **YES NO**
5. Abdomen Normal **YES NO**	*11. Mental Status* Normal **YES NO**
6. Pelvis Normal **YES NO**	*12. Other* Normal **YES NO**

COMMENTS:

_____

_____

_____

MEDICAL HISTORY: If you answer **YES** to any of these questions, please explain in the space provided below.

1. Does the Participant have any history of allergy, anaphylaxis, or asthma? **YES NO**
2. Is the Participant currently undergoing treatment for any medical condition? **YES NO**
3. Does the Participant have any physical limitations that we should be aware of? **YES NO**
4. Are you aware of any history of psychological disorder, i.e. depression, anxiety, eating disorders, etc. **YES NO**

COMMENTS:

_____

_____

_____

MEDICAL CLEARANCE:

On the basis of the Participant's medical history and your physical examination, do you feel that this individual can successfully and safely participate in an SFS program as described in the Program Information for Participants and Medical Professionals section at the top of this form? **YES NO**

Examiner's Name (Please Print): _____

Medical Degree (Please Circle): M.D. D.O. P.A. R.N.P

Office Address: _____

Email Address: _____

Office Phone Number: _____ Office Fax Number: _____

Signature: _____ Date: _____

Please submit by fax to: 978-232-1254 "Attn: Safety Department" or by post mail to: The School for Field Studies, Attn: Safety Department, 100 Cummings Center, Suite 534-G, Beverly, MA 01915