



UNIVERSITY OF DALLAS

Dear Doctor:

The purpose of this letter is to help you decide whether a certain student can safely participate in our Study Abroad Program.

The following have arisen as significant medical problems for some of our students while studying abroad: diabetes, depression, anxiety, asthma, thyroid conditions, severe allergies, poor social skills, ADHD, and eating disorders.

Access to medical care can be problematic abroad for several reasons:

- language barrier (most physicians and nurses do not speak English)
- lack of mental health services
- limited or non-existent access for commonly prescribed medications used in the US
- a prohibitive customs process for prescriptions, especially regarding meds for ADD

Therefore, it is in the best interest of all students that any medical condition be stable and that a two-month supply of medications be brought abroad.

In addition to the above potential obstacles to medical care, the Study Abroad Program is physically, emotionally, and socially demanding:

- the schedule involves miles and miles of walking and climbing throughout cities and country sides as well as to and from bus stops and train stations, often carrying heavy backpacks and other luggage
- unusual dietary needs are often impossible to meet
- there is no extra staff available to stay with students whose health condition requires rest to prevent a serious incident; nor do we have staff who specialize in counseling
- students must have the skills to live well in community with a packed schedule and close quarters
- students must have the maturity and judgment to manage in an environment in which alcohol and other drugs are readily available
- college courses are rigorous with strict attendance requirements and the usual exams and papers to write; this can be especially difficult for students who have problems in or outside of the classroom.
- students must have been stable on the same course of treatment for at least one semester prior to studying abroad

Please consider all of these concerns as you fill out the attached form to certify that the student is medically, physically, and emotionally fit to safely participate in this challenging Study Abroad Program.

Sincerely,

Rebecca Davies, Director
Rome & Summer Programs

DUE DATE:
March 20, 2018

Health Clearance for University of Dallas Summer Study Abroad Program
Physician Questionnaire

_____ is applying to participate in our University of Dallas Study Abroad Program for Summer 2018 in (country):_____. Access to adequate medical care is problematic, so students must be stable enough on current medication regimens to withstand two months without routine intervention. Please read the enclosed letter from Mrs. Rebecca Davies, Director of Rome & Summer Programs, and provide us with an updated evaluation of the student's fitness for participation in our Study Abroad Program. (Please attach extra sheets or make copies if needed for multiple conditions)

1. Diagnosis/Description of medical condition:

2. Treatment and/or Medication and dosage:

Two month supply of medication has been prescribed/given to student

3. Potential side effects of medication:

4. Do you anticipate that the student may need to adjust this medication regimen over the next 2 months?

If yes, explain:

5. If the student has a psychiatric problem, given the dearth of English speaking counselors abroad and the absence of up to date emergency psychiatric facilities, is the student stable enough to proceed without counseling or a change in medication for the next 2 months?

If no, explain:

6. Based on your close reading of Mrs. Davies' letter, are you able to verify the student's general physical and emotional fitness for participation in the Study Abroad Program?

If there are any concerns, please explain:

Please return to Rebecca Davies, Director, University of Dallas Rome Office, 1845 E. Northgate Drive, Irving, TX 75062-4736. If you have any questions please phone her at 972-721-5206 or you may email her at bdavies@udallas.edu . The form may be faxed to 972-721-5283.

Doctor's Name (print): _____

Doctor's Signature: _____ Date: _____

Doctor's Address: _____

Doctor's Telephone Number: _____