ASSOCIATION OF AMERICAN PROGRAMS IN SPAIN (AAPS)
GENERAL MARTINEZ CAMPOS, 24 BIS – 1º
28010 MADRID
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HEALTH ASSESSMENT FORM

Name of Student: _____

Passport Number:_____

Date of Birth:_____

This is to certify that _____was examined at/by _____ (University/Health Service/Family Physician) on _____(date) and was found

___a) to be in good general health, free of any communicable and quarantinable disease (including cholera, yellow fever, and the plague), and as far as we can determine, based on the physical exam and discussion with this student, he/she is drug free and is emotionally healthy, showing no signs of major psychological disorders such as delirium, hallucinations, or psychosis.

Or

___b) to be under supervised medical treatment for the following:

_____

_____

OBSERVATIONS:

Examining Physician:

Name:_____ Telephone:_____

Address:_____

Signature:_____

Date:_____

Medical Licensing or D.E.A. Prescribing number:_____

APUNE/AAPS Form 4