Heritage Greece® Program 2027
Physician's Medical Form

Instructions: Please review the information contained on this page with your doctor.

NOTES TO THE EXAMINING PHYSICIAN:

The Heritage Greece® Program is hosted by the American College of Greece in Athens. The Heritage Greece® experience requires student participants to exercise physical and mental capabilities. It is imperative, as a safeguard to the health of the participant, that this report be as complete and precise as possible.

This form should be completed by a licensed physician who preferably has known the applicant for at least 12 months prior to departure. Students are expected to meet the following requirements:

- Possess the physical and mental wellbeing and capacity required to participate in program hosted in a foreign setting where resources and the environment differs from what they are accustomed to back home;
- Exercise good judgment and discretion to fulfill essential program components, including appropriate standards of conduct;
- Display flexibility to function if faced with uncertain and/or stressful situations; and,
- Participate in typical classroom work and planned excursions and activities, which includes moderate physical activity (e.g., walking in heat to ancient sites and museums, hiking, swimming, various other sports activities, dancing, etc.).

In addition, any applicant who has been under the care of a specialist (for example, cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) **must** submit a written, detailed report from said specialist to give a complete diagnosis, prognosis, and evaluation. It is imperative that Heritage Greece® receives a written report from a specialist to decide the eligibility of the participant.

If a participant is required to continue receiving medication while under the auspices of the Program, he/she should have a medical letter giving such details with a full explanation. Since medicine is often not available under the same trade name as in the country of origin, the full pharmacological name of all medicines and drugs used by the patient should be given. In any event, participants should bring an extra supply of the required medicine with him/her, some of which should be entrusted to the group leader**.**

If any changes take place in the participant's condition within the last ten days **before departure**, the participant must submit an explanatory medical letter detailing diagnosis, prognosis, and treatment.

Failure to submit such a letter shall result in expulsion of the applicant from the Program.

PLEASE EVALUATE THE APPLICANT'S MEDICAL CONDITION IN LIGHT OF THE FOLLOWING FACTORS THAT DESCRIBE THE PROGRAM:

Social Environment: Most participants will be living in a communal environment. They will be sleeping in a dormitory or sharing living quarters with many other people and eating in communal dining facilities.

Activity: The participants will be expected to participate in extensive tours of the country, which will include walking long distances, climbing, hiking, swimming, and related strenuous activities in Greece's hot summer climate. In addition, the participants will be free to use the athletic facilities of ACG (swimming pool, weight room, sports facilities, etc.)

Medical Facilities: The physician should also bear in mind that the American College of Greece has a first aid infirmary staffed by a registered nurse. All acute illnesses and serious accidents are referred for proper diagnosis and treatment to local hospitals and/or local doctors. There are no facilities on campus for the treatment of chronic conditions.

The information on this form, and all supplementary letters and reports, on the physical, mental, or psychological condition of the applicant shall be held as confidential and protected materials.

Should any participant upon arrival in Greece, or during their stay, be found to be suffering from any physical, mental or related undisclosed condition that is not included on this Physician's Medical Form, or in an accompanying letter from a qualified and licensed medical professional, then:

> He/she may, at the sole and absolute discretion of the American College of Greece, or its representatives in Greece or in the United States, be returned to his/her location of origin at the participant's own expense (and there shall be no refund on deposits paid for the Program.)
>
> The American College of Greece, National Hellenic Society, and their respective representatives in the United States and in Greece are thereby fully released from responsibility or liability of any kind whatsoever arising out of any aspect of such participant's medical history, physical and mental condition, and shall be indemnified by the participant for any and all expenses incurred as a result of the failure to fully disclose material information related to the physical and/or mental health of the student.

ALL SECTIONS MUST BE COMPLETED IN FULL AND WILL BE TREATED CONFIDENTIALLY

NAME OF PARTICIPANT: _____

DATE: _____

TELEPHONE: _____

PHYSICAL EXAMINATION:

Weight:_____Height:_____ Respiration:_____

Hearing: _____

Blood Pressure:_____Vision:_____

Pulse: _____

Any considerations bearing on student's physical/mental health?

PSYCHOLOGICAL EXAMINATION:

1. a) Is the participant currently involved in or has ever been advised to seek psychiatric or mental health therapy of any kind for any mental health condition (e.g. depression, anxiety)?

   Please Circle: **YES / NO**

   b) If yes, please indicate dates of start and end of treatment:

2. If yes, please explain the nature of therapy:

3. The American College of Greece requires information pertaining to all medical conditions that have been diagnosed and all prescribed medication and medical treatment that the student is currently undergoing. Please list below:

PHYSICIAN STATEMENT:

I have read the “Notes to Examining Physician” on the cover of the examination form and thereafter have examined_____ whom I have known for _____ years/months.

If first time visit, please indicate name of clinic and date:

_____

The results I have recorded represent, to the best of my knowledge, all of the participant’s medical history and my findings on examination. In my opinion the participant is physically, mentally and emotionally capable of participating in the program as outlined in “Notes to Examining Physician.”

I recommend full physical activity: □Yes □No If no, explain:

I recommend certain restrictions: □Yes □No If yes, explain:

I recommend a special diet: □Yes □ No If yes, explain:

Name of Licensed Physician: **(Please Print)**

_____

Phone: ( ) _____

Address: _____

X_____

Physician’s Signature

PARTICIPANT STATEMENT:

I have read the "Notes to Examining Physician" on the Medical Examination Form.

I hereby certify that, to the best of my knowledge, this Physician's Medical Form is a comprehensive report of my physical, mental condition complete in all its details and fully realize that any undisclosed physical, mental or related condition described herein, or in an accompanying letter may disqualify me from further participation in the Heritage Greece Program and necessitate my repatriation to my country of origin, and/or require treatment in Greece, at my own expense.

Accordingly, I acknowledge and affirm that the American College of Greece and National Hellenic Society do not bear responsibility, liability or expense arising out of such circumstances.

All medication that I take regularly is at my own expense and has been detailed on this Physician's Medical Form or accompanying documentation. I also understand that ACG does not operate medical facilities other than a first aid infirmary, and I will be referred to local doctors and/or local hospitals for proper diagnosis and treatment of any serious illness or accident. I also give my full permission for the treatment of any material condition deemed necessary for my wellbeing as determined and undertaken licensed physicians and practioners in Greece.

MUST BE COMPLETED BY PARTICIPANT:

Participant Name:

_____

Passport Number and expiry date:

_____

Name of Health Insurance Provider:

_____

Policy/Group Number:

_____

Are you a vegetarian or have special dietary requirements that we will need to accommodate while you are in Greece?

_____

Do you have any learning disabilities? If so, please list and describe requirements to accommodate:

_____

Please list any allergies that you have (as well as what you use to treat them):

_____

Please list all medications and dosages that you are currently taking, prescribed and over the counter:

_____

_____

Any other health conditions, treatment, therapy, or considerations that we need to be aware of during your participation in the Heritage Greece® Program?

_____

_____

_____

_____

Have you ever suffered from, been treated for, taken medication for, or been hospitalized for the following:

Mental health condition (e.g. depression, anxiety, bipolar)?

□Yes □No If yes, explain:

_____

_____

Substance abuse (alcohol, drugs)?

□Yes □No If yes, explain:

_____

_____

I verify that the foregoing information is complete, true and accurate and have an ongoing responsibility to report any changes in my health status to the American College of Greece:

Signature:

_____

Date: _____