PHYSICAL REPORT

All summer program participants must have this form completed by a physician.

Patient's Name | Date of Birth | Sex

To the examining physician:
The American School of Classical Studies at Athens (ASCSA) welcomes scholars to an academically rigorous and stimulating environment. Individuals may require accommodations for physical, mental, or emotional conditions and we welcome your assistance in determining what accommodations may be necessary. Archaeological sites are outdoors, and trips typically require standing and walking or hiking during all seasons and weather. Temperatures in Greece during the late spring and early fall regularly reach the 90s F. We request, therefore, to be made aware of any conditions, past or current, that may affect the patient during these trips. This information will be reviewed only by the School's doctor and will remain confidential; it will be shared with other staff, faculty, or appropriate professionals only if pertinent to the patient's immediate health and safety. This information does not affect their admission to the School.

Should an emergency occur with the patient during their residence at the School, we request the following information about the patient's medical conditions and your recommendations for their care:

MEDICAL CONDITIONS AND MEDICINE

Is the patient under treatment for any medical condition:

☐ Yes. *Explain below and list any specific medications the patient is currently taking.* ☐ No

If your patient is on medication, does any of their medication need refrigeration:

☐ Yes. *Explain below and list any specific medications.* ☐ No

PHYSICAL ACTIVITY

Has the patient's physical activity been restricted during the past five years:

☐ Yes. *Give reasons and durations.* ☐ No

Does your patient have ambulatory concerns (For example: Do they use a cane? Do they have trouble with stairs? Can they walk over uneven terrain?):

☐ Yes. *Explain below.* ☐ No

Does your patient have trouble with heat intolerance or issues with "overheating:"

☐ Yes. *Explain below how we could help.* ☐ No

Does your patient have trouble with sleep? Some accommodations may be shared with 1-3 participants.

☐ Yes. *Explain below how we could help.* ☐ No

Recommendations for physical activity:

☐ Limited. *Explain below*. ☐ Unlimited

ALLERGIES AND SENSITIVITIES

Does your patient have any allergies (to medication, food, or otherwise):

☐ Yes. *Explain below.* ☐ No

Does your patient have any "sensitivities" that program leaders should be made aware of (For example: Are they gluten intolerant? Do they have light or sound sensitivity concerns?):

☐ Yes. *Explain below.* ☐ No

Do you have any recommendations regarding the care of this patient:

☐ Yes. *Explain below.* ☐ No

Flip over, complete other side →

Surgeries/hospitalizations/prescribed medications/allergies/other remarks not previously noted:

Use this space to address additional information where you have marked "**yes**" to any above question:

Please consult with the patient about their participation in this program and discuss any potential limitations they may have or accommodations they may need.

Physician's signature Date

Address of Physician's office

Telephone/Fax/Email for Physician's office