



ASSOCIATION OF AMERICAN PROGRAMS IN SPAIN (AAPS)

GENERAL MARTINEZ CAMPOS, 24 BIS – 1º

28010 MADRID

TEL. (34) 913 199 1 1 8 - FAX (34) 913 085 704

**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: \_\_\_\_\_