AMERICAN FARM SCHOOL
Thessaloniki Greece

Greek Summer

A COMMUNITY SERVICE & TRAVEL ODYSSEY

MEDICAL FORM –PAGE A

TO THE APPLICANT: After you have filled out the above, give this form to your physician. Upon receipt of the physician's completed form, please review and add any additional information or clarification you deem necessary to ensure the Greek Summer staff are fully aware of all relevant health issues. Sign, date and return this form as soon as possible. **NO APPLICATION WILL BE CONSIDERED COMPLETE WITHOUT THIS SIGNED AND REVIEWED MEDICAL EXAMINATION FORM**. All information submitted will be held confidential by the American Farm School.

Applicant Information

Name of Applicant: _____

Address of Parent/Guardian:_____

City: _____ **State:**_____ **Zip:** _____

Phone: (_____**)** _____ **Email:**_____

Health Insurance of Applicant

Carrier: _____

Policy Number: _____

Family Physician: _____

Address: _____

City: _____ **State:**_____ **Zip:**_____

Phone: (_____**)** _____ **Email:**_____

TO THE PHYSICIAN: This student is applying to the Greek Summer Program of the American Farm School. We need the information requested below to determine the student's ability to participate, both mentally and physically, in a rigorous work and travel program in a foreign country. Please complete this form as soon as possible and return it to the applicant's parent or guardian. Thank you for your help.

A. Medical History
Does the applicant have:

1. Limitations to physical activity? Yes ☐ No ☐
2. Any recurrent or chronic condition? Yes ☐ No ☐
3. Any allergies? Yes ☐ No ☐
4. A history of insomnia or enuresis? Yes ☐ No ☐
5. A history of emotional disturbance? Yes ☐ No ☐
6. Indications of the following:
   a. Difficulties in relationships with parents, authority figures, or peers? Yes ☐ No ☐
   b. Behavioral disorders? Yes ☐ No ☐
   c. Emotional symptoms? (mood swings, depression, severe sleep disorders, unusual degree of anxiety, fear or guilt, ADD) Yes ☐ No ☐
   d. An eating disorder? Yes ☐ No ☐
   e. Treatment for substance abuse? Yes ☐ No ☐
   f. Other: Yes ☐ No ☐
7. Has the applicant been to a psychiatrist in the last four years? Yes ☐ No ☐

(If the answer is "yes" a confidential report from a psychiatrist has to be sent to our office)

If you answered YES for any of the above questions, please provide detail of dates and treatment status.
(Use a separate page if necessary)

_____

_____

B. Medical Examination
Does the applicant have:

8. Any weight related problems (being underweight or overweight)? Yes ☐ No ☐
9. Any dietary restrictions or food allergies? Yes ☐ No ☐
10. Any physical disabilities, which might cause hardship through change of diet, carrying his/her own luggage, or strenuous travel? Yes ☐ No ☐
11. Any speech, hearing, or eyesight impairment, which might affect his/her participation in the program? Yes ☐ No ☐
12. Any congenital malformation now existing that may require additional treatment? Yes ☐ No ☐
13. Any predisposing medical, surgical or emotional factors which may, under stress or during the program, present a need for immediate therapy while participating? Yes ☐ No ☐
14. Menstrual difficulties that may affect her participation in an active program? Yes ☐ No ☐

If you answered YES on Question 12 please provide details on what treatment is to be pursued.

_____

_____

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MEDICAL FORM – PAGE B

Summary Evaluation

You would consider the applicant's physical condition as: Poor ☐ Fair ☐ Excellent ☐

Please comment on the applicant's nervous/emotional stability?

_____

_____

Greek Summer includes an approximately 6-hour hike (10,000 ft.) on Mt. Olympus. Is there any reason the applicant should not participate in the hike, engage in athletics or join the community service construction project?
Disclaimer: We would like to inform parents and guardians that it will be left to the discretion of the staff and counselors to allow individual campers to participate in the Mt. Olympus hike.

_____

_____

_____

If there is any other information that would be helpful to us, please use the space below. Are there any recommendations to the American Farm School's physician regarding this applicant's health?

_____

_____

Reminder about health insurance. Parents or guardians are required to provide participants with health insurance for the duration of the program to cover any unforeseen medical emergencies. The American Farm School recommends that families extend their existing health insurance policies to cover their children while in Greece.

Date:_____/_____/_____ ***Signature of examining physician***:_____

Please return completed form to the applicant parent and guardian for a review and submission.

Parent/Guardian Review

I have reviewed the above information and found it accurate and complete.

Date:_____/_____/_____ ***Signature of parent or guardian***:_____

After completing the **Medical Form** please return it to:

Greek Summer Admissions
American Farm School
greeksummer@afs.edu.gr
54 Marinou Antipa Street, PO Box 23,
551 02 Thessaloniki, Greece