



SAIIE

"Your Life Experience; Your Education"

Health Statement Form

SAIIE (Spanish-American Institute of International Education) requires all participants in its academic, athletic, and internship programs to provide a medical report signed by a physician confirming that they are in suitable physical and mental health necessary to participate safely and fully in their SAIIE program.

Therefore, please present this form to your personal physician so that a confidential statement can be provided regarding your ability to participate in the program.

We encourage you to discuss with your physician any physical or mental health conditions, medications, or other health concerns that may affect your ability to live, study, train, work, or otherwise participate in your program while abroad. Your physician can advise you on any precautions, treatment, or support that may be appropriate during your time in Spain.

Full Name of Participant: _____

Date of birth: ____/____/____

I am participating in the:

- ☐ Study Abroad Program
- ☐ Internship Abroad Program
- ☐ Gap Year Abroad

If participating in an athletic program, please check one::

- ☐ Beach Volleyball ☐ Soccer ☐ Swimming ☐ Rowing ☐ Volleyball ☐ Rugby
- ☐ Water Polo ☐ Not Applicable

Program Term in Seville, Spain:

- ☐ Spring 2027
- ☐ Summer I, 2027
- ☐ Summer II, 2027
- ☐ Summer I & II, 2027
- ☐ Fall 2027
- ☐ Academic Year 2027/28



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To the Physician:

To your knowledge, does the above-named individual have any physical, emotional, mental, or medical conditions that could affect their ability to safely participate in their SAIIE program, including academic, internship, or athletic activities?

Is there any medical information that SAIIE should be aware of in the event of an emergency, such as allergies, medications, or other relevant medical conditions?

Please provide any recommendations, restrictions, or precautions that you believe SAIIE should be aware of during the participant's time abroad.

I have examined the above name individual and have found the student in good physical, emotional and mental health to travel, study abroad, participate in an athletic program if chosen and participate in this program.

Physician's Name: _____

Medical Specialty: _____

Name and Location of Health Care Facility: _____

Telephone: _____

Email: _____

Physician's Signature: _____

Clinic/Physician Stamp (if available): _____

Date: _____ / _____ / _____

MM DD YYYY