**District**

**Applicant Name**

**Long-Term Exchange Program**

**Medical History and Examination**

**Physician:** This student is considering a year abroad as an exchange student. Insufficient, inadequate, or improper information about medications or psychiatric, psychological, or other medical problems could endanger the student’s life while overseas. Allergy information is especially crucial to host family placement and student well-being. An immediate relative of the applicant may **not** complete the examination or fill out this form.

*Please type or print clearly. Please submit four copies of the form, with original signatures in* ***blue*** *ink on each copy.*

|  |  |  |
| --- | --- | --- |
| **Applicant’s Full Legal Name** | **Gender** | **Date of Birth** (e.g., 01/Jan/1999) |
|  | Male Female |  |
| **Address — Street** |
|  |
| **City** | **State/Province** | **Postal Code** | **Country** |
|  |  |  |  |
| **Home Phone** | **Mobile Phone** | **E-mail** |
|  |  |  |

# Medical History

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| --- | --- |
| **1. How long has the applicant been the patient of the physician?** |  |
| **2. Has the applicant ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for:** |
| **Yes No Yes No**1. Allergies n. Liver disease/hepatitis
2. Anorexia/bulimia/other eating disorder o. Menstrual disorders
3. Appendicitis p. Mental disorders
4. Arthritis q. Pneumonia
5. Asthma r. Rheumatic fever
6. Bowel problems s. Serious headache/migraine
7. Cancer t. Stomach ulcer
8. Diabetes u. Typhoid fever
9. Epilepsy/seizures v. Urinary tract infection
10. Hearing loss w. Vertigo/dizziness
11. Heart disease x. Visual problems
12. Hernia y. Eyeglasses/contact lenses
13. Malaria
 |
| **3. Has the applicant:** |
| a. Had any surgical operation not revealed in question 2, or gone to a hospital, clinic, dispensary, or sanatorium for observation, examination, or treatment not revealed in question 2? | **Yes No** |
| b. Taken any prescribed medication in the past six months? |  |
| c. Presented any history or current evidence of nervous, emotional, or mental abnormality, functional nervous breakdown, nervous fatigue, depression, suicide attempts, eating disorders, or antisocial behavior? |  |
| d. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs? |  |
| e. Ever received treatment for or advice about a problem with alcohol or drug use, either from a physician/other practitioner or an organization that assists those who have an alcohol or drug problem? |  |
| f. Had excessive weight gain or loss recently? |  |
| g. Suffered chest pain, wheezing, shortness of breath, or fainting episodes? |  |
| h. Suffered chronic diarrhea, vomiting, abdominal pain, or constipation? |  |
| i. Exhibited chronic skin conditions (e.g., severe acne, eczema, psoriasis)? |  |
| j. Suffered weakness of neurological or muscular skeletal system? |  |
| k. Had any dietary restrictions? If yes, specify and note reason (medical, religious, personal choice): |  |
| **If yes for any parts of questions 2 and 3, please explain:** |
| **Question** (e.g., 2e) | **Nature and severity of disorder, diagnosis, frequency of attacks, and treatment** | **Dates and duration** |
|  |  |  |
|  |  |  |
|  |  |  |

**Applicant Name**

**4. Will the applicant be bringing any prescribed medication on the exchange? Yes No**

If yes, please list each medication, including the international and generic names, compound symbols, dosage, frequency, and reason for use:

**Prescribed Medication**

**Dose/Frequency**

**Reason for Use**

|  |
| --- |
| **5. Indicate year when the applicant had the following infectious diseases (or indicate that he or she has not):** |
| Measles (rubeola) |  | Mumps |  | Hepatitis |  | Whooping cough (pertussis) |  |
| Rubella (German measles) |  | Chicken pox |  | Scarlet fever |  | Other: |  |
| **6. The applicant has been immunized against the following diseases** (clearly state the dates of last booster and doses received):*Immunizations are a prerequisite to school attendance in many locations. The host country or school may require additional immunizations.* |
| **Immunization** | **Number of Doses** | **Dates**(e.g., 01/Jan/2006) | **Immunization** | **Number of Doses** | **Dates**(e.g., 01/Jan/2006) |
| Diphtheria |  |  | Measles (rubeola) |  |  |
| Whooping cough (pertussis) |  |  | Polio (Sabin-3 or more TOPV, Salk-4 or more IPV) |  |  |
| Tetanus |  |  | Hepatitis B |  |  |
| Rubella (German measles) |  |  | Other (specify)  |  |  |
| Mumps |  |  |
| Additional comments: |
| **7. Tuberculosis screening: The applicant must present evidence of recent (within 3 months) Mantoux/PPD skin test.** |
| Date of screening (*e.g.*, 01/Jan/2006) Result/diagnosis: . If a different test was administered or the applicant received a BCG vaccine, please explain methods and treatments used to obtain screening results: |

# Physical Examination

|  |  |  |  |
| --- | --- | --- | --- |
| Height: | Weight: | Blood Pressure: Sys. Dia. | Pulse rate/minute: |
| **8. Does today’s examination show any abnormal findings for:** |
| Yes NoHead and neck Ear, nose, throat Chest/lungs | Yes NoHeart (murmur, pressure)HerniasLymph nodes/breasts Genitalia | Yes NoExtremities (muscular) Skeletal system Neurological | Yes NoAbdomen (mass) RectalSkin |
| If yes, please provide detailed information on a separate page *(typed or computer-generated with the applicant’s full legal name and date of birth at the top of each page)*. |

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| **CERTIFICATION**I certify that I hold a valid current license to practice medicine and am not an immediate relative of the patient, and that I have personally examined the applicant and reported my findings as noted above and the attached page(s) (if no pages are attached, please check here: ).I find the applicant:In good health and not suffering from any mental or medical condition(s) that would preclude participation in the program Suffering from mental or medical condition(s) as noted in my reportI find the applicant in good health and not suffering from any condition(s) that would preclude participation in sporting/physical activities of theapplicant’s choice. Yes No |
| **Physician’s Name** (type or print) | **Signature** (in blue ink) | **Date** (e.g., 01/Jan/2006) |
|  |  |  |
| **Physician’s address, phone, and fax** (type or stamp) |