



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.

<b>Applicant's Full Legal Name</b>		<b>Gender</b>	<b>Date of Birth</b> (e.g., 01/Jan/1999)
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Address — Street</b>			
<b>City</b>	<b>State/Province</b>	<b>Postal Code</b>	<b>Country</b>
<b>Home Phone</b>	<b>Mobile Phone</b>	<b>E-mail</b>	

### Medical History

<b>1. How long has the applicant been the patient of the physician?</b>			
<b>2. Has the applicant ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for:</b>			
	<b>Yes</b>	<b>No</b>	
a. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	n. Liver disease/hepatitis
b. Anorexia/bulimia/other eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	o. Menstrual disorders
c. Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	p. Mental disorders
d. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	q. Pneumonia
e. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	r. Rheumatic fever
f. Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	s. Serious headache/migraine
g. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	t. Stomach ulcer
h. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	u. Typhoid fever
i. Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	v. Urinary tract infection
j. Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	w. Vertigo/dizziness
k. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	x. Visual problems
l. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	y. Eyeglasses/contact lenses
m. Malaria	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. Has the applicant:</b>			
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?	<b>Yes</b>	<b>No</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	
b. Taken any prescribed medication in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Had excessive weight gain or loss recently?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Suffered chest pain, wheezing, shortness of breath, or fainting episodes?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Suffered chronic diarrhea, vomiting, abdominal pain, or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Exhibited chronic skin conditions (e.g., severe acne, eczema, psoriasis)?	<input type="checkbox"/>	<input type="checkbox"/>	
j. Suffered weakness of neurological or muscular skeletal system?	<input type="checkbox"/>	<input type="checkbox"/>	
k. Had any dietary restrictions? If yes, specify and note reason (medical, religious, personal choice):	<input type="checkbox"/>	<input type="checkbox"/>	
<b>If yes for any parts of questions 2 and 3, please explain:</b>			
<b>Question</b> (e.g., 2e)	<b>Nature and severity of disorder, diagnosis, frequency of attacks, and treatment</b>		<b>Dates and duration</b>

Applicant Name	
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<b>4. Will the applicant be bringing any prescribed medication on the exchange?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list each medication, including the international and generic names, compound symbols, dosage, frequency, and reason for use:		
<b>Prescribed Medication</b>	<b>Dose/Frequency</b>	<b>Reason for Use</b>

<b>5. Indicate year when the applicant had the following infectious diseases (or indicate that he or she has not):</b>							
Measles (rubeola)		Mumps		Hepatitis		Whooping cough (pertussis)	
Rubella (German measles)		Chicken pox		Scarlet fever		Other:	

<b>6. The applicant has been immunized against the following diseases</b> (clearly state the dates of last booster and doses received):					
<i>Immunizations are a prerequisite to school attendance in many locations. The host country or school may require additional immunizations.</i>					
<b>Immunization</b>	<b>Number of Doses</b>	<b>Dates</b> (e.g., 01/Jan/2006)	<b>Immunization</b>	<b>Number of Doses</b>	<b>Dates</b> (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:

<b>7. Tuberculosis screening: The applicant must present evidence of recent (within 3 months) Mantoux/PPD skin test.</b>
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:							
<b>8. Does today's examination show any abnormal findings for:</b>											
	Yes	No		Yes	No		Yes	No			
Head and neck	<input type="checkbox"/>	<input type="checkbox"/>	Heart (murmur, pressure)	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (muscular)	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (mass)	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>	Skeletal system	<input type="checkbox"/>	<input type="checkbox"/>	Rectal	<input type="checkbox"/>	<input type="checkbox"/>
Chest/lungs	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes/breasts	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Genitalia	<input type="checkbox"/>	<input type="checkbox"/>						

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).

<b>CERTIFICATION</b>		
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: <input type="checkbox"/> ).		
I find the applicant:		
<input type="checkbox"/> In good health and not suffering from any mental or medical condition(s) that would preclude participation in the program		
<input type="checkbox"/> Suffering from mental or medical condition(s) as noted in my report		
I find the applicant in good health and not suffering from any condition(s) that would preclude participation in sporting/physical activities of the applicant's choice. <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Physician's Name</b> (type or print)	<b>Signature</b> (in blue ink)	<b>Date</b> (e.g., 01/Jan/2006)
<b>Physician's address, phone, and fax</b> (type or stamp)		