STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS
2012 SUMMER OUTBOUND PROGRAM
MEDICAL FORM
- to be completed by physician

Delegate's Name:_____ State:_____

Destination Country: _____ Date of Birth:_____
Month/Day/Year

To the Examining Physician: This individual is applying for a cross-cultural exchange program. Delegates live as a member of a family in a host country. Not everyone is equipped mentally and physically for this experience. The applicant must have a high degree of motivation and the ability to adjust to different social and cultural backgrounds--sometimes under difficult circumstances. Sound health is vital. Your careful and complete evaluation of the applicant's health will be helpful in determining his/her assignment. If the applicant is accepted for participation, necessary immunizations will be required. ***This form must be completed based on the examination which occurred after January 1, 2014.**

1. **Inoculation History**

Vaccine	Number	Date of injection	Vaccinated by/at	Contracted or not?	Date contracted (M/D/Y)
Measles	1st			Yes / No	
	2nd				
Mumps	1st			Yes / No	
	2nd				
Rubella	1st			Yes / No	
	2nd				
Chickenpox				Yes / No	
Polio (OPV)	1st			Yes / No	
	2nd				
	3rd				
	4th				
DPT Diphtheria Pertussis Tetanus	1st			Yes / No	
	2nd				
	3rd				
	4th				
	5th				
Tuberculosis					
Hepatitis B	1st				
	2nd				
	3rd				
Others					

2. Is this person subject to any of the following? If YES, please explain condition and/or frequency.

			Condition/Frequency
Asthma/Respiratory Problems	Yes ☐	No ☐	_____
Diabetes/Hypoglycemia	Yes ☐	No ☐	_____
Heart Trouble	Yes ☐	No ☐	_____
Lung Trouble	Yes ☐	No ☐	_____
Fainting Spells	Yes ☐	No ☐	_____
Convulsions	Yes ☐	No ☐	_____
Epilepsy	Yes ☐	No ☐	_____
Skin Disease	Yes ☐	No ☐	_____
Kidney/Gall Bladder/Liver Disease	Yes ☐	No ☐	_____
Muscular/Skeletal Problem	Yes ☐	No ☐	_____
Emotional or Mental Disorder	Yes ☐	No ☐	_____
Stomach/Intestinal Problem	Yes ☐	No ☐	_____

Any Other Disorder (Please list and explain)

_____

_____

3. Does he/she have any allergies or reactions to drugs or non-drug items?

- **Medicines**:

  Penicillin or Related Drugs: Yes☐ No☐

  Aminopyrine or Sulpyrine Type Drug: Yes☐ No☐

  Others:_____

  Types and degree of reaction:_____

- **Non-Drug Items:**

  Bees ☐ Pollen,☐ Dogs ☐ Cats ☐ Small Animals ☐

  Foods: _____

  Other non-food items:_____

  Types and degree of reaction:_____

4. Does he/she have difficulties with any of the following?

			Remarks
Eyes	Yes ☐	No ☐	_____
Uses Contact Lenses	Yes ☐	No ☐	_____
Ears	Yes ☐	No ☐	_____
Nose	Yes ☐	No ☐	_____
Throat	Yes ☐	No ☐	_____
Digestion	Yes ☐	No ☐	_____
Sleepwalking	Yes ☐	No ☐	_____
Bed-Wetting	Yes ☐	No ☐	_____
Menstrual problems	Yes ☐	No ☐	_____

Any other Difficulties: (Please list)_____

- Any surgical operations, accidents, or injuries which required hospitalization in the past?

  Yes ☐ No ☐ Explain: _____

- Any recent exposure to a contagious disease?

  Yes ☐ No ☐ Explain:_____

- If applicant is carrying medicines/prescriptions, fill in the following. Put "P" for prescriptions.

Name of medicine	For what illness/symptoms	Dosage/Times taken

- Are there any physical activities that applicant is restricted from doing? If YES, please list.

  Yes ☐ No ☐ If so, what kind?_____

- Any additional information the host parents should be aware of?

  Yes ☐ No ☐ Explain:_____

- Is this person currently under a doctor's care (for reasons other than routine care)?

  Yes ☐ No ☐ Explain:_____

- Considering the statements above, your examination, and any information you may have provided in connection with the above questions, is there any reason you would question this applicant's participation in this program?

  Yes ☐ No ☐ Explain:_____

For additional comments, please use an extra sheet of paper.

Date of examination upon which this report is based:_____

I have given a thorough physical examination and reviewed the medical history of the delegate. I certify that all important medical information has been included and that the above information is complete and accurate.

Physician's Name/Address	**Physician's official stamp and signature**
_____ _____ Date: Month/Day/Year_____	