STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS
2019 SUMMER OUTBOUND PROGRAM
MEDICAL FORM

Chaperone's Name:_____ Date of Birth:_____
Month/Day/Year

Destination Country:_____ State:_____

Must be completed by a physician

To the Examining Physician: This individual is applying as a chaperone for a cross-cultural exchange program. Chaperones 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/their assignment. If the applicant is accepted for participation, necessary immunizations will be required. ***This form must be completed based on the examination which occurs within one year of the date of departure.**

1. **Does the applicant 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:_____

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

		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 ☐	_____
Anxiety	Yes ☐ No ☐	_____
Depression	Yes ☐ No ☐	_____

Any Other Conditions (Please list and explain): _____
_____

3. Does this person 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)_____

4. Any surgical operations, accidents, or injuries which required hospitalization in the past?
Yes ☐ No ☐ Explain: _____

5. Are there any physical activities that the applicant is restricted from doing?
Yes ☐ No ☐ If YES, please list: _____

6. If an applicant is carrying medicines/prescriptions, fill in the following.

Name of Medicine	Illness/Symptoms	Dosage/Times Taken

7. Any recent exposure to a contagious disease?
Yes ☐ No ☐ Explain: _____

8. Is this person currently under a doctor's care (for reasons other than routine care)?
Yes ☐ No ☐ Explain: _____

9. Any additional information the host parents should be aware of?
Yes ☐ No ☐ Explain: _____

10. Inoculation History - fill out below or attach vaccination records.

Vaccine	Number	Date of injection	Vaccinated by/at	Contracted?	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	☐			Yes ☐ No ☐	
Hepatitis B	1st ☐			Yes ☐ No ☐	
	2nd ☐				
	3rd ☐				
Others				Yes ☐ No ☐	

11. 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 person'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 chaperone. I certify that all important medical information has been included and that the above information is complete and accurate.

Physician's Name/Address

_____

_____

Date: Month/Day/Year_____

Physician's signature