



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

Delegate'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 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/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 the applicant have difficulties with any of the following?

Remarks

Eyes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Uses Contact Lenses	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Ears	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Nose	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Throat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Digestion	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Sleepwalking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Bed-Wetting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Menstrual problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
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 this person 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 <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
	2nd <input type="checkbox"/>				
Mumps	1st <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
	2nd <input type="checkbox"/>				
Rubella	1st <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
	2nd <input type="checkbox"/>				
Chickenpox	<input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
Polio (OPV)	1st <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
	2nd <input type="checkbox"/>				
	3rd <input type="checkbox"/>				
	4th <input type="checkbox"/>				
DPT Diphtheria Pertussis Tetanus	1st <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
	2nd <input type="checkbox"/>				
	3rd <input type="checkbox"/>				
	4th <input type="checkbox"/>				
	5th <input type="checkbox"/>				
Tuberculosis	<input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hepatitis B	1st <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>	
	2nd <input type="checkbox"/>				
	3rd <input type="checkbox"/>				
Others				Yes <input type="checkbox"/> No <input type="checkbox"/>	

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 his/her/their 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.

<p>Physician's Name/Address</p> <p>_____</p> <p>_____</p> <p>Date: Month/Day/Year _____</p>
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<p>Physician's signature</p>
