STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS
2020 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 ☐ 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 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 ☐			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 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.

Physician's Name/Address	**Physician's signature**
______________________________ ______________________________ Date: Month/Day/Year__________________	