STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS
2017 SUMMER OUTBOUND PROGRAM
MEDICAL FORM (CHAPERONES)

Participant's Name: _____ Date of Birth: _____
Month/Date/Year

Destination Country: _____ State: _____

To the Examining Physician: This individual will be chaperoning a group of youths participating in a cross-cultural exchange program. The applicant must have a high degree of motivation and the ability to adjust to different social and cultural backgrounds, and help the youths deal with difficult circumstances. Sound health is vital. Your careful and complete evaluation of the applicant's health will be helpful in determining his/her assignment. *** This form must be completed based on the examination which occurs within one year of the date of departure.**

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	☐			Yes ☐ No ☐	
Hepatitis B	1st ☐			Yes ☐ No ☐	
	2nd ☐				
	3rd ☐				
Others				Yes ☐ No ☐	

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 ☐	_____

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? _____

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

  Yes ☐ No ☐ Explain: _____

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

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