



STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS 2017 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 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 <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"/>	

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

Condition/Frequency

Asthma/Respiratory Problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Diabetes/Hypoglycemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heart Trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Lung Trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Fainting Spells	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Skin Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Kidney/Gall Bladder/Liver Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Muscular/Skeletal Problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Emotional or Mental Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Stomach/Intestinal Problem	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
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 <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) _____

- 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.

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