



# STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS 2018 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 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 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: \_\_\_\_\_

#### 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  \_\_\_\_\_

Any Other Disorder (Please list and explain): \_\_\_\_\_

\_\_\_\_\_

**3. 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) _____		

**4. Any surgical operations, accidents, or injuries which required hospitalization in the past?**

Yes  No  Explain: \_\_\_\_\_  
 \_\_\_\_\_

**5. Are there any physical activities that the he/she 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 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><b>Physician's Name/Address</b></p> <p>_____</p> <p>_____</p> <p>Date: Month/Day/Year _____</p>
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<p><b>Physician's signature</b></p>
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