MEDICAL FORM 작성 요청

한국4-H본부는 법률 제8758호 '한국4에이치활동지원법'에 근거한 '4-H활동주관단체'로서 1947년부터 농업후계인력 및 농심함양을 통한 전인적 청소년 육성을 담당하고 있는 청소년교육기관입니다.

2020년 7월부터 8월까지 1달간 미국에 파견하는 'S4-H 미국 파견 프로그램' 에 참가하기 위한 서류 중에 하나로 의사선생님께서 작성하신 Medical Form이 필요합니다.

뒷면에 작성한 자료를 참고하시어 작성해주시면 감사하겠습니다.

관련해서 문의사항이 있으시면 아래 담당자에게 연락부탁드립니다.

한국4-H본부 담당자
김상원 대리 (010-4038-5260)

❑ 메디컬폼 작성예시

STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS
MEDICAL FORM
- to be completed by a physician -

Participant's Name: [redacted]

Country of Residence: **South Korea** Date of Birth: _____
Month/Day/Year

To the Examining Physician: This individual is applying for a cross-cultural exchange program. Participants live as a member of a family in the United States. 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.

1. **Inoculation History**

Vaccine	Number	Date of injection	Vaccinated by/at	Contracted or not?	Date contracted (M/D/Y)
Measles	1st	04/16.2003	Sunsa Pediatrics Clinic	Yes / (No)	
	2nd	04/23/2008	Public health center Seo-gu Daejeon		
Mumps	1st	04/16.2003	Sunsa Pediatrics Clinic	Yes / (No)	
	2nd	04/23/2008	Public health center Seo-gu Daejeon		
Rubella	1st	04/16.2003	Sunsa Pediatrics Clinic	Yes / (No)	
	2nd	04/23/2008	Public health center Seo-gu Daejeon		
Chickenpox		04/16/2003	Sunsa Pediatrics Clinic	Yes / (No)	
Polio (OPV)	1st	03/26/2002	Busan St. Mary's Hospital	Yes / (No)	
	2nd	07/09/2002	Konyang Univ. Hospital		
	3rd	12/11/2002	Sunsa Pediatrics Clinic		
	4th	07/16/2008	Public health center Seo-gu Daejeon		
DPT Diphtheria Pertussis Tetanus	1st	03/26/2002	Busan St. Mary's Hospital	Yes / (No)	
	2nd	07/29/2002	Konyang Univ. Hospital		
	3rd	12/11/2002	Sunsa Pediatrics Clinic		
	4th	12/16/2003	Sunsa Pediatrics Clinic		
	5th	07/16/2008	Public health center Seo-gu Daejeon		
Tuberculosis					
Vaccine type for TB		01/28/2002	Haedong Hospital	Yes / (No)	
Hepatitis B	1st	01/10/2002	Haedong Hospital	Yes / (No)	
	2nd	02/11/2002	Haedong Hospital		
	3rd	03/12/2002	Busan St. Mary's Hospital		
Others					

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)	
Psychological Disorder	Yes	(No)	
Stomach/Intestinal Problem	Yes	(No)	
Any Other Disorder (Please list and explain)	Yes	(No)	

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: _____

- **Non-Drug Items:**

Bees Pollen Dogs Cats Small Animals

Foods_____

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)	
	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)	
Psychological Disorder	Yes	(No)	
Stomach/Intestinal Problem	Yes	(No)	
Any Other Disorder (Please list and explain)	Yes	(No)	

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: _____

- **Non-Drug Items:**

Bees Pollen Dogs Cats Small Animals

Foods_____

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)	
	Yes	No	

Physician's Name/Address	Physician's official stamp and/or signature
Sun Dong shin 64 Tanbang-dong Seogu DAEJEON Korea Date: Month/Day/Year 28/01/2016	