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

Participant's Name:_____

Country of Residence: _____ 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			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					
Vaccine type for TB					
Hepatitis B	1st				
	2nd				
	3rd				
Others					

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

	Yes	No	Condition/Frequency
Asthma/Respiratory Problems	☐	☐	
Diabetes/Hypoglycemia	☐	☐	
Heart Trouble	☐	☐	
Lung Trouble	☐	☐	
Fainting Spells	☐	☐	
Convulsions	☐	☐	
Epilepsy	☐	☐	
Skin Disease	☐	☐	
Kidney/Gall Bladder/Liver Disease	☐	☐	
Muscular/Skeletal Problem	☐	☐	
Psychological Disorder	☐	☐	
Stomach/Intestinal Problem	☐	☐	
Any Other Disorder (Please list and explain)	☐	☐	

3. Does he/she have any allergies or reactions to drugs or non-drug items?

- **Medicines**:

	Yes	No	
Penicillin or Related Drugs:	☐	☐	
Aminopyrine or Sulpyrine Type Drug:	☐	☐	

Others: _____

- **Non-Drug Items:**

Bees ☐ Pollen☐ Dogs ☐ Cats ☐ Small Animals ☐

Foods_____

4. Does he/she have difficulties with any of the following?

	Yes	No	Remarks
Eyes	☐	☐	
Uses Contact Lenses	☐	☐	
Ears	☐	☐	
Nose	☐	☐	

Throat	☐ Yes	☐ No	_____
Digestion	☐ Yes	☐ No	_____
Sleepwalking	☐ Yes	☐ No	_____
Bed-Wetting	☐ Yes	☐ No	_____
Menstrual problems	☐	☐	_____

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?

  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 candidate. 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/or signature**
_____ _____ Date: Month/Day/Year_____	