STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS
2020 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/their 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 the applicant 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 ☐	_____
Anxiety	Yes ☐ No ☐	_____
Depression	Yes ☐ No ☐	_____

Any Other Conditions (Please list and explain): _____
_____

3. **Does the applicant 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 ☐	
Bed-Wetting	Yes ☐ No ☐	
Menstrual problems	Yes ☐ No ☐	

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 this person 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 ☐			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 ☐	

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/their 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.

Physician's Name/Address

_____

_____

Date: Month/Day/Year_____

Physician's signature