



# STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS MEDICAL FORM (Minor) - to be completed by physician

Participant'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. Participants 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.

## 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.**

**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: \_\_\_\_\_

• **Non-Drug Items:**

Bees  Pollen,  Dogs  Cats  Small Animals

Foods \_\_\_\_\_

**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?

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.

<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 official stamp and signature</b></p>
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