



# STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS 2020 SUMMER OUTBOUND PROGRAM MEDICAL FORM

Chaperone'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 as a chaperone for a cross-cultural exchange program. Chaperones 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 this person 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 applicant 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 this person'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 chaperone. 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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