**Applicant's Name** _____

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*Please type or print clearly.*

## **Part I—Student Information** (to be completed by student)

Student's Full Legal Name _____

Gender: ◯ Male ◯ Female Date of Birth (MONTH/DAY/YEAR) _____/_____/_____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____

E-mail _____

## **Part II—Medical History** (to be completed by physician/medical doctor in consultation with the student)

***Important:*** *Physician, this student is considering a year abroad as an international student. Insufficient, inadequate, or improper information about medications or psychiatric, psychological, or other medical conditions could endanger the student's life while overseas. Allergy information is especially crucial to host family placement and student well-being. An immediate relative of the student may* ***not*** *complete the examination or fill out this form.*

1. How long has the student been a patient of yours? _____

2. Has the student ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for the following allergies?:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| A. Aspirin | ◯ Yes | ◯ No | D. Insect stings/bites | ◯ Yes | ◯ No | G. Other _____ | | |
| B. Food | ◯ Yes | ◯ No | E. Penicillin | ◯ Yes | ◯ No | | | |
| C. Hay fever | ◯ Yes | ◯ No | F. Poison ivy/oak/other | ◯ Yes | ◯ No | H. Does the student carry an epinephrine autoinjector (such as EpiPen)? | ◯ Yes | ◯ No |

For any *yes* answers, please explain—below or on a separate sheet of paper (numbered 2A)—the disorder's nature and severity, the diagnosis, the frequency of attacks, and the treatment dates and duration. (If you need to attach additional pages, include the student's full legal name and date of birth at the top of each page).

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3. Has the student ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for any disease, impairment, or abnormality of:

- Altitude sickness ◯ Yes ◯ No
- Allergies ◯ Yes ◯ No
- Anorexia/bulimia/other eating disorder ◯ Yes ◯ No
- Appendicitis ◯ Yes ◯ No
  Has the student's appendix been removed? ◯ Yes ◯ No
- Arthritis ◯ Yes ◯ No
- Asthma ◯ Yes ◯ No
- Autoimmune disease (any) ◯ Yes ◯ No
- Blood or endocrine system ◯ Yes ◯ No
- Bones, joints, or locomotion system ◯ Yes ◯ No
- Bowel problems ◯ Yes ◯ No
- Brain or nervous system ◯ Yes ◯ No
- Cancer ◯ Yes ◯ No
- Communicable disease (any) ◯ Yes ◯ No
- Depression ◯ Yes ◯ No
- Diabetes ◯ Yes ◯ No
- Ears or hearing ◯ Yes ◯ No
- Eyes or vision ◯ Yes ◯ No
  Does the student wear corrective eyeglasses/contact lenses? ◯ Yes ◯ No
- Epilepsy ◯ Yes ◯ No
- Genitourinary system ◯ Yes ◯ No
- Hearing loss ◯ Yes ◯ No
- Heart disease ◯ Yes ◯ No
- Heart or blood vessels ◯ Yes ◯ No
- Hernia ◯ Yes ◯ No
  Has the student ever been operated on for a hernia? ◯ Yes ◯ No
- Hypertension ◯ Yes ◯ No
- Liver disease/hepatitis ◯ Yes ◯ No
- Lungs, respiratory system ◯ Yes ◯ No
- Malaria ◯ Yes ◯ No
- Menstrual disorders ◯ Yes ◯ No
- Mental or emotional disorders ◯ Yes ◯ No
- Pneumonia ◯ Yes ◯ No
- Rheumatic fever ◯ Yes ◯ No
- Scarlet fever ◯ Yes ◯ No
- Seizures ◯ Yes ◯ No
- Serious headache/migraine ◯ Yes ◯ No
- Serious or persistent cough ◯ Yes ◯ No
- Skin ◯ Yes ◯ No
- Stomach or digestive system ◯ Yes ◯ No
- Stomach ulcer ◯ Yes ◯ No
- Tonsils, nose, or throat ◯ Yes ◯ No
  Have the student's tonsils been removed? ◯ Yes ◯ No
- Typhoid fever ◯ Yes ◯ No
- Urinary tract infection ◯ Yes ◯ No
- Vertigo/dizziness ◯ Yes ◯ No
- Other _____ ◯ Yes ◯ No

For any *yes* answers, please explain—below or on a separate sheet of paper (numbered 3A)—the disorder's nature and severity, the frequency of attacks, and the treatment dates and duration.

4. Has the student:

A. Had any surgical operation not covered in question 2 or 3 or been hospitalized or treated for any other condition not covered in question 2 or 3? ◯ Yes ◯ No

B. Taken any prescribed medication in the past six months? ◯ Yes ◯ No

C. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs? ◯ Yes ◯ No

D. Ever received treatment for or advice about a problem with alcohol or drug use, either from a physician or other practitioner or an organization that assists those who have an alcohol or drug problem? ◯ Yes ◯ No

E. Had excessive weight gain or loss recently? ◯ Yes ◯ No

F. Had any dietary restrictions for medical, religious, or personal reasons? ◯ Yes ◯ No

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Please explain any *yes* answers below or on a separate sheet of paper (numbered 4A). (If you need to attach additional pages, include the student's full legal name and date of birth at the top of each page).

5. Will the student be bringing any prescribed medication to the host country? ◯ Yes ◯ No
   If yes, please list each medication, including the international and generic names, compound symbols, dosage, frequency, and reason for use:

| Prescribed Medication | Dose/Frequency | Reason for Use |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

6. Indicate whether the student has had the following infectious diseases and the date(s) **(MONTH/DAY/YEAR)** the student had the disease(s):

| | | | | | |
|---|---|---|---|---|---|
| Hepatitis A | ◯ Yes, date(s): ___/___/_____ | ◯ No | Rubella (German/3-day measles) | ◯ Yes, date(s): ___/___/_____ | ◯ No |
| Hepatitis B | ◯ Yes, date(s): ___/___/_____ | ◯ No | Scarlet fever | ◯ Yes, date(s): ___/___/_____ | ◯ No |
| Measles (rubeola/10-day red measles) | ◯ Yes, date(s): ___/___/_____ | ◯ No | Tuberculosis | ◯ Yes, date(s): ___/___/_____ | ◯ No |
| Mumps | ◯ Yes, date(s): ___/___/_____ | ◯ No | Varicella (chicken pox) | ◯ Yes, date(s): ___/___/_____ | ◯ No |
| Pertussis (whooping cough) | ◯ Yes, date(s): ___/___/_____ | ◯ No | Other: _____ | ◯ Yes, date(s): ___/___/_____ | ◯ No |

## Part III—School Immunization Record (to be completed by physician/medical doctor)

**Physician**—*The student is required to be immunized for measles, mumps, and rubella (MMR) within the last 10 years to enter school in the United States and some other countries. Previous illness is not accepted as immunization in some schools. Additional immunizations may be necessary to meet state , provincial, and country requirements upon arrival. Please clearly state the dates of each immunization. The student has been immunized against the following diseases:*

| Vaccine | Record date of each advised immunization (MONTH/DAY/YEAR) | | | | |
|---|---|---|---|---|---|
| Hepatitis A | 1st ___/___/_____ | 2nd ___/___/_____ | | | |
| Hepatitis B | 1st ___/___/_____ | 2nd ___/___/_____ | 3rd ___/___/_____ | | |
| DPT: Diphtheria | 1st ___/___/_____ | 2nd ___/___/_____ | 3rd ___/___/_____ | 4th ___/___/_____ | 5th ___/___/_____ |
| Pertussis (whooping cough) | 1st ___/___/_____ | 2nd ___/___/_____ | 3rd ___/___/_____ | 4th ___/___/_____ | 5th ___/___/_____ |
| Tetanus (within last 10 years) | 1st ___/___/_____ | 2nd ___/___/_____ | 3rd ___/___/_____ | 4th ___/___/_____ | 5th ___/___/_____ |
| MMR: Measles (rubeola/10-day red measles) | 1st ___/___/_____ | 2nd ___/___/_____ | | | |
| Mumps | 1st ___/___/_____ | 2nd ___/___/_____ | | | |
| Rubella (German/3-day measles) | 1st ___/___/_____ | 2nd ___/___/_____ | | | |
| Polio | 1st ___/___/_____ | 2nd ___/___/_____ | 3rd ___/___/_____ | 4th ___/___/_____ | |
| Varicella (chicken pox) | 1st ___/___/_____ | | | | |
| Other (specify) _____ | 1st ___/___/_____ | 2nd ___/___/_____ | 3rd ___/___/_____ | 4th ___/___/_____ | 5th ___/___/_____ |

Additional comments:

The student must present evidence of recent (within 3 months) tuberculosis screening. Screening date: **(MONTH/DAY/YEAR)** ___/___/_____.

Mantoux tuberculin skin test result/diagnosis: _____ OR QuantiFERON®-TB Gold test result/diagnosis: _____

Was the student ever treated for tuberculosis? ◯ **Yes, date(s): (MONTH/DAY/YEAR)** ___/___/_____ ◯ **No**

If yes, please explain the treatment method: _____

Did the student ever receive a BCG vaccine? ◯ **Yes, date(s): (MONTH/DAY/YEAR)** ___/___/_____ ◯ **No**

**Applicant's Name** _____

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## PART IV—Physical Examination (to be completed by physician/medical doctor)

Age _____ Height: _____ Weight: _____ Blood Pressure: Sys _____ Dia _____ Pulse rate/minute: _____

Are reflexes normal for: Pupils ◯ Yes ◯ No Knees ◯ Yes ◯ No Other (please specify) _____ ◯ Yes ◯ No

Does today's examination show any abnormal findings for:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Head and neck | ◯ Yes | ◯ No | Lymph nodes/breasts | ◯ Yes | ◯ No | Abdomen (mass) | ◯ Yes | ◯ No |
| Ear, nose, throat | ◯ Yes | ◯ No | Genitalia | ◯ Yes | ◯ No | Rectal | ◯ Yes | ◯ No |
| Chest/lungs | ◯ Yes | ◯ No | Extremities (muscular) | ◯ Yes | ◯ No | Skin | ◯ Yes | ◯ No |
| Heart (murmur, pressure) | ◯ Yes | ◯ No | Skeletal system | ◯ Yes | ◯ No | | | |
| Hernias | ◯ Yes | ◯ No | Neurological | ◯ Yes | ◯ No | | | |

Please explain any *yes* answers below or on a separate sheet of paper (numbered 5A). (If you need to attach additional pages, include the student's full legal name and date of birth at the top of each page).

## Part V—Certification (to be completed by physician/medical doctor)

I certify that I hold a valid current license to practice medicine and am not an immediate relative of the patient. I certify that I have personally examined the student and reported my findings as noted in the Medical Information pages of this international student medical form and any attached page(s). I further state that all the information I have supplied is true and accurate to the best of my knowledge.

Check one:
◯ I have attached _____ additional pages
◯ I have not attached additional pages

Check one:
◯ I find the student in good health and **not** suffering from any mental or medical condition(s) that would preclude studying in another country as an international student.
◯ I find the student suffering from mental or medical condition(s), as noted in my report, that **would preclude studying** in another country as an international student.

Check one:
◯ I find the student in good health and **not** suffering from any condition(s) that would preclude participation in sporting/physical activities.
◯ I find the student suffering from a condition(s) as noted in my report that **would preclude participation** in sporting/physical activities.

**Physician's Name** (please print) _____

**Signature** _____ **Date** _____

Address—Street _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____

E-mail _____