



STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS MEDICAL FORM

Participant's Name: _____

Country of Residence: _____ Date of Birth: _____
Month/Day/Year

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. Have you ever had or been inoculated for, any of this following? Fill in the blanks with checks and/or necessary information.

	Inoculated		Contracted		Month & Year of latest Inoculation		
	Yes ___	No ___	Yes ___	No ___	Month	Year	
Measles	Yes ___	No ___	Yes ___	No ___	_____	_____	
Mumps	Yes ___	No ___	Yes ___	No ___	_____	_____	
Rubella	Yes ___	No ___	Yes ___	No ___	_____	_____	
Chicken Pox	Yes ___	No ___	Yes ___	No ___	_____	_____	
Polio	Yes ___	No ___	Yes ___	No ___	_____	_____	
DPT	Yes ___	No ___	Yes ___	No ___	_____	_____	
Diphtheria	Yes ___	No ___	Yes ___	No ___	_____	_____	
Pertussis	Yes ___	No ___	Yes ___	No ___	_____	_____	
Tetanus	Yes ___	No ___	Yes ___	No ___	_____	_____	
Tuberculosis	Yes ___	No ___	Yes ___	No ___	_____	_____	
Hepatitis B	Yes ___	No ___	Yes ___	No ___	_____	_____	
Covid-19 (Primary series)	Yes ___	No ___	Yes ___	No ___	_____	_____	
Covid-19 Booster						_____	_____
Tetanus	Yes ___	No ___			_____	_____	
If you are not up to date, are you planning on re-inoculation?					Yes ___	No ___	

2. Do you have or are you 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"/>	_____
Psychological 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)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

3. Do you 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. Do you 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 you are 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 you are 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: _____

- Are you currently under a doctor's care?

Yes No Explain: _____

For additional comments, please use an extra sheet of paper.

I hereby authorize States' 4-H International, or any person authorized by States' 4-H International, including my child's host parents and 4-H Coordinator of this exchange program, to make decisions regarding medical or surgical care and emergency travel arrangements as needed for the well-being of my child. Furthermore, I authorize the release of any medical records regarding my child to States' 4-H or any person authorized by States' 4-H.

<p>Full Name of Parent (or guardian)</p> <p>_____</p> <p>_____</p>

<p>Signature of Parent (or guardian)</p> <p>Date: Month/Day/Year:</p>
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