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**	
						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 ☐	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 ☐	
Psychological Disorder	Yes ☐	No ☐	
Stomach/Intestinal Problem	Yes ☐	No ☐	
Any Other Disorder (Please list and explain)	Yes ☐	No ☐	

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 ☐	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) _____

- 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.

Full Name of Parent (or guardian)	**Signature of Parent (or guardian)**
_____	**Date: Month/Day/Year:**