**Medical Information & Physician’s Report Authorization for Emergency Transportation/Medical Treatment**

Participants Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/We hereby authorize the sponsoring organization in the host country and/or parents of the host family to make arrangements for the participant’s welfare while participating in this program. This includes transportation in the event of an emergency and for whatever emergency medical care may be deemed necessary for the participant’s health and welfare.

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name & Relationship of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The contact listed below will be informed as soon as possible should emergency treatment be required.

In case of emergency (Full Name & Relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternative emergency contact (Full Name & Relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician (Name, Address & Phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Examining Physician**: this individual is applying to participate in an international, cross-cultural exchange program. Participants live as members of a family in another country, may perform physical labor, and may be exposed to unusual health risks. Not everyone is equipped mentally and physically for this experience. The applicant must have a high degree of motivation and 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 their assignment. Thank you for ensuring the participant is up to date on all necessary vaccinations and tetanus injections.

**Medical History**: Please fill in the blanks with checks and provide supplemental information as needed. HAVE YOU EVER HAD, OR BEEN INOCULATED, FOR ANY OF THE FOLLOWING

Contracted Inoculated Month / Year of Injection

Diphtheria yes no yes no

Polio yes no yes no

Scarlet Fever yes no yes no

Smallpox yes no yes no

Typhus yes no yes no

German Measles yes no yes no

Measles yes no yes no

Whooping cough yes no yes no

Chicken Pox yes no yes no

Mumps yes no yes no

Tetanus Inoculations preventive injection yes no last injection:

Serum injection yes no last injection:

Is the participant subject to any of the following? If “yes”, please explain. Include any needed treatment

Asthma/Respiratory problems: Yes No

Diabetes/Hypoglycemia: Yes No

Ear 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 problems Yes No

Any other disorder or problems- please list and explain:

Does the participant have difficulties with any of the following? If “yes”, please explain

Eyes Yes No

Uses contact lenses/glasses Yes No

Ears Yes No

Nose Yes No

Throat Yes No

Digestion Yes No

Sleepwalking Yes No

Bedwetting Yes No

Menstrual Problems Yes No

Any other difficulties-please list and explain:

Blood type:

Does the participant have any allergies or reactions to drugs, food or other non-drug items?

Medicines:

Penicillin & related drugs Yes No

List any other drug allergies

Non-drug allergies such as dust, pollen, animal dander, etc:

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Any surgical operations, accidents or injuries within the past 2 years which required hospitalization?

Yes No

Any recent exposure to a contagious disease?

Yes No

If the participant will be carrying medicines/prescriptions-please complete the following:

Please provide participant with a legible and complete prescription for all medications needed for travel

(Name of medicine generic & name brand, treating what, dosage and frequency)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: units of measure for medicines may differ by country. It may be difficult or even impossible to obtain the exact kind of medicine you normally take; even with a prescription. Consider taking a sufficient number of essential medications with you

Is the participant on any special diet? If “yes”, describe any medical reason for such:

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Are there any specific physical activities the participant must avoid? Describe & specify limits.

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Is the participant currently under a doctor’s care for other than general health maintenance? Explain:

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Any additional information that a host family or emergency physician should be aware of?

Considering the statements above, your evaluation, and any information you may have in connection with the participant, is there any reason you would question the applicant’s participation in an international exchange program?

Yes No Any explanation

DATE OF EXAMINATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S FULL NAME, ADDRESS, TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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