



INTERNATIONAL 4-H YOUTH EXCHANGE



MEDICAL INFORMATION FORM AND PHYSICIAN'S REPORT AUTHORIZATION FOR EMERGENCY TRANSPORTATION/MEDICAL TREATMENT

Participant's Name: _____

State: _____
(Please type or print)

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

Dated: _____
Participant's Signature

Dated: _____
Signature of Parent or Guardian
(If participant is under 18)

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

In case of emergency notify: _____ Telephone: (_____) _____

Relationship to participant: Parent Guardian Other _____

Alternate emergency contact: _____ Telephone: (_____) _____

Family physician or clinic: _____ Telephone: (_____) _____

MEDICAL HISTORY: Please fill in the blanks with checks and provide supplemental information.

1. Have you ever had, or been inoculated for any of the following?

	CONTRACTED		INOCULATED		MONTH & YEAR OF LAST INJECTION
Diphtheria	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
Polio	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
Scarlet Fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
Smallpox	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
Typhus	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
German Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
Measles	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
Whooping Cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____
Chicken Pox	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____ 20_____

International Four-H Youth Exchange Association of the USA

5811 Lone Oak Drive East, Bethesda, Maryland 20814-1843
Telephone: (301) 493-5301 or E-mail: lfyeassociation@aol.com



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Mumps Yes No Yes No _____ 20_____

Tetanus Inoculations: Preventive Injection: Yes No Last Injection_____ 20_____

Serum Injection: Yes No Last Injection_____ 20_____

Participants should carry a copy of this form with them. Send original to state International Program Coordinator.

To the Examining Physician: This individual is applying to participate in an international, cross-cultural exchange program. Participants live as a member 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 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 their assignment. If the applicant is accepted for participation, necessary immunization will be required.

2. Is this person subject to any of the following? If "YES," please explain condition and/or frequency.

Condition/Frequency

Asthma/Respiration 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 Problem Yes No _____

Any other disorder (please list and explain: _____

3. Does the participant have difficulties with any of the following?

Eyes Yes No Remarks: _____

Uses contact lenses Yes No Remarks: _____

Ears Yes No Remarks: _____

Nose Yes No Remarks: _____

Throat Yes No Remarks: _____

Digestion Yes No Remarks: _____

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Sleepwalking Yes No Remarks: _____

Bed-Wetting Yes No Remarks: _____

Menstrual Problems Yes No Remarks: _____

Any other difficulties (please list): _____

4. Any surgical operations, accidents, or injuries, which required hospitalization in the last two years? Yes No
Explain: _____

5. Any recent exposure to a contagious disease? Yes No Explain: _____

6. Blood type: _____

7. Does the participant have any allergies or reactions to drugs or non-drug items?
Medicines: Penicillin or related drugs: Yes No Aminopyrine or sulpyrine-type medicine: Yes No

Others
(list): _____

Non-drug items, such as dust, pollen, cat-hair, etc.
(list): _____

8. If applicant is carrying medicines/prescriptions, fill in the following:

Name of Medicine	For what illness/symptoms?	Dosage/Times Taken?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE TO APPLICANT: Units of measurement for medicine in other countries may be different from those in the U.S. It is also difficult, or sometimes impossible, to obtain the same kind of medicine that you use at home, even though you may have the prescription with you. Therefore, we suggest that you bring sufficient amounts of your own medicine with you.

9. Is the participant on a special diet? Yes No If so, what kind? _____

10. If there are any physical activities that applicant is restricted from doing, please list:

11. Is this person currently under a doctor's care? Yes No Explain: _____

12. Any additional information the host family should be aware of:



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Considering the statements above, your examination, and any information you have in connection with this applicant, is there any reason you would question the applicant's participation in this program?

Yes No Explain: _____

For additional comments, please attach additional pages.

Date of examination upon which this report is based: _____

Physician's Name & Address: _____

Dated: _____

(Physician's official stamp and signature).

Please return to the International Program Coordinator in your state. Contact your County Extension Office, State 4-H Office, or the below address for additional information.

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