Applicant's Name _____

Medical Information

Part 1: Student Information (to be completed by student)

Student's Full Legal Name _____

Gender: Male ☐ Female ☐ Date of Birth (Month/Day/Year) ____/____/_____

Address _____

City _____ State/Province _____ Postal Code _____ Country _____

Home Phone _____ Cell Phone _____

Email _____

Part 2: 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 the student's 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: □ D. Insect Stings/bites: □ G. Other _____
   - B. Food: □ E. Penicillin: □ H. Does the student carry an epinephrine autoinjector (EpiPen?) □
   - C. Hay fever: □ F. Poison ivy/oak/other: □

   If yes, please explain:
   _____
   _____
   _____
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
- □ Allergies
- □ Anorexia/bulmia/ other eating
- □ Arthritis
- □ Asthma
- □ Autoimmune disease (any)
- □ Blood or endocrine system
- □ Bones, joints, or locomotion system
- □ Bowel problems
- □ Brain or nervous system
- □ Cancer
- □ Communicable disease (any)
- □ Depression
- □ Diabetes
- □ Ears or hearing
- □ Eyes or vision (Does student wear eyeglasses/contacts)
- □ Epilepsy
- □ Genitourinary system
- □ Hearing loss
- □ Heart disease
- □ Heart or blood vessels
- □ Hernia (Has the student ever been operated on for a hernia)
- □ Hypertension
- □ Liver disease/hepatitis
- □ Lungs, respiratory system
- □ Malaria
- □ Menstrual disorders
- □ Mental or emotional disorders
- □ Pneumonia
- □ Rheumatic fever
- □ Scarlet fever
- □ Seizures
- □ Serious or persistent cough
- □ Skin
- □ Stomach or digestive system
- □ Stomach ulcer
- □ Tonsils, nose, or throat (Have student's tonsils been removed?)
- □ Typhoid fever
- □ Urinary tract infection
- □ Vertigo/dizziness
- □ Other _____

4. Has the student:
    - □ Had any surgical operation not covered in questions 2 or 3 or been hospitalized or treated for any other condition not covered in question 2 or 3?
    - □ Taken any prescribed medication in the past six months?
    - □ Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs?
    - □ 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?
    - □ Had excessive weight gain or loss recently?
    - □ Had any dietary restrictions for medical, religious, or personal reasons?

Please explain any yes answers below for questions 3 and/or 4 below:

_____
_____
_____
_____
_____

5. Will the student be bringing any prescribed medication to the host country? □
   If yes, please list each medication, including the international and generic names, compounds symbols, dosage, frequency, and the 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 — Date(s): _____/_____/_____
    - □ Hepatitis B — Date(s): _____/_____/_____
    - □ Measles (rubeola/10-day red measles) — Date(s): _____/_____/_____
    - □ Mumps — Date(s): _____/_____/_____
    - □ Pertussis — Date(s): _____/_____/_____
    - □ Rubella (German/3-day measles) — Date(s): _____/_____/_____
    - □ Scarlet fever — Date(s): _____/_____/_____
    - □ Tuberculosis — Date(s): _____/_____/_____
    - □ Varicella (chicken pox) — Date(s): _____/_____/_____
    - □ Other: _____ — Date(s): _____/_____/_____

Part 3: 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
- □ Ear, nose, throat
- □ Chest/ Lungs
- □ Heart (Murmur, pressure)
- □ Hernias
- □ Lymph nodes/breasts
- □ Genitalia
- □ Extremities
- □ Skeletal system
- □ Neurological
- □ Abdomen (mass)
- □ Rectal
- □ Skin

Please explain any abnormal findings:

_____
_____

Part 4: 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

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_____

City _____ State/Province _____Postal Code _____ Country _____

Home Phone _____Cell Phone _____

E-mail _____

Dental Information

Dentist: This student is considering studying abroad as an international student. Insufficient, inadequate, or improper information about the student's dental health, medications, or other problems could endanger this student while overseas. An immediate relative of the student may not complete the dental examination.
Student's Full Legal Name

_____

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

Address_____
City _____ State/Province _____Postal Code _____Country _____
Home Phone _____ Cell Phone _____
E-mail

_____

Dental Examination
1. Is the student in good dental health? □ Yes □ No
2. Does the student require dental work at this time? □ Yes □ No
3. Do you foresee the student requiring any dental work while abroad? □ Yes □ No
If you answered yes to question 3, please provide detailed information on a separate page (typed or computer-generated with the student's full legal name and date of birth at the top of each page).
I certify that I hold a valid current license to practice dentistry and am not an immediate relative of the patient. I certify that I have personally examined the student and reported my findings as noted above on the Dental Information page 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
Dentist's Name (please print)

_____

Signature _____ Date _____

Address_____

City _____ State/Province _____Postal Code _____ Country _____

Home Phone _____Cell Phone _____

E-mail

_____

Medical Release

Authorization for Medical Care and Release of Medical Records and Liability

Please read carefully. Sign and date below where indicated.

I/We, the undersigned parent(s)/legal guardian(s) (hereafter parents) of the student, and I, the student, if of legal age, hereby authorize the release of medical and dental information in the International Student Medical Form acquired in the course of the examinations by the physician and the dentist. I/We, the parent(s), and the student, who have the sole and legal right to make the decisions on the health and care of the student, do release from liability and grant permission as noted of the following while he/she is overseas as an international student attending _____ (*hereafter school*):

- In the event of accident or sickness, I/we authorize any school staff and/or host parent(s) of the student to select the appropriate medical facility and physician(s)/dentist(s) to provide treatment.
- I/We hereby authorize and consent to any X-ray examination, administration of anesthetic, blood transfusion, surgical operation, or any other medical or surgical diagnosis and treatment rendered under the general or special supervision of any member of the medical staff and emergency-room staff licensed by the state of treatment and/or the provisions of the Medical Treatment Act, or a dentist licensed by the state of treatment and/or under the provisions of the Dental Treatment Act, or staff of any acute general hospital holding a current license to operate a hospital.
- I/We further consent to any medical or surgical treatment by a licensed physician, surgeon, or dentist that might be required by my/our son/daughter for any emergency situation. I/We do request that I/we be notified as soon as possible, but emergency treatment need not be delayed to provide such notice.
- Permission is granted for any additional immunizations that may be required per school and state regulations.
- It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but it is given to provide authority and power to render care which the aforementioned physician or dentist in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. In the case of elective surgery, I/we request that I/we be notified and our permission obtained before such arrangements are made.
- I/We agree to hold harmless and release from all liability the school and all staff or all members of the host family for any intervention in an emergency situation regardless of final outcome. I/We agree to assume all financial obligations beyond those covered by health, accident, and sickness insurance for any medical treatment rendered.

Father's/Legal Guardian's Name (please print)

_____

Signature (mandatory if student is under age 18) _____ Date _____

Address_____

City _____ State/Province _____Postal Code _____ Country _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mother's/Legal Guardian's Name (please print)

_____

Signature (mandatory if student is under age 18) _____ Date _____

Address_____

City _____ State/Province _____Postal Code _____ Country _____

Home Phone _____ Cell Phone _____ Work Phone _____

Student's Name (please print)

_____

Signature _____ Date _____

Witness' Name (please print)

_____

Signature _____ Date _____