CT International 4-H Youth Exchange Program

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

PARTICIPANT'S FULL NAME:
COMPLETE HOME ADDRESS:

DATE OF BIRTH:

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: **DATE:**

SIGNATURE OF PARENT/GUARDIAN: **DATE:**
IF participant under 18 yrs of age

PRINTED NAME AND RELATIONSHIP OF PARENT/GUARDIAN:

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

IN CASE OF EMERGENCY-NOTIFY:
Print full name and relationship to participant

EMERGENCY TELEPHONE NUMBER(s):

Alternate emergency contact-name-telephone-relationship:

Family Physician(print name, address, telephone numbers):

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:

Name of participant:

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 and related drugs Yes No
List any other drug allergies:

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

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 and brand names	For what illness/symptoms	Dosage/Frequency
1.		
2.		
3.		

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 amount of essential medications with you.

NAME OF PARTICIPANT:

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

Are there any specific physical activities the participant must avoid or refrain from? If "yes", describe and specify limits.

Is the participant currently under a doctor's care for other than general health maintenance? If "yes", please explain:

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: