Rotary District ☐ | **Applicant Name**

Rotary Youth Exchange – Long-Term Exchange Program

Medical History and Examination, Page 1 of 2

Physician: This student is considering a year abroad as an exchange student. Insufficient, inadequate, or improper information about medications or psychiatric, psychological, or other medical problems could endanger the student's life while overseas. Allergy information is especially crucial to host family placement and student well-being. An immediate relative of the applicant may **not** complete the examination or fill out this form.

*Please type or print clearly. Please submit multiple copies of the form as directed, with original signatures in **blue** ink on each copy.*

Applicant's Full Legal Name	Date of Birth	☐ Male ☐ Female

Medical History

1. How long has the applicant been the patient of the physician?	

2. Has the applicant ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for:

	Yes	No		Yes	No
a. Allergies	☐	☐	n. Liver disease/hepatitis	☐	☐
b. **Anorexia/bulimia/other eating disorder***	☐	☐	o. Malaria	☐	☐
c. Appendicitis	☐	☐	p. Menstrual disorders	☐	☐
d. Arthritis	☐	☐	q. **Mental disorders***	☐	☐
e. Asthma	☐	☐	r. Pneumonia	☐	☐
f. **Attention deficit disorder***	☐	☐	s. Rheumatic fever	☐	☐
g. Bowel problems	☐	☐	t. Serious headache/migraine	☐	☐
h. Cancer	☐	☐	u. Stomach ulcer	☐	☐
i. Diabetes	☐	☐	v. Typhoid fever	☐	☐
j. Epilepsy/seizures	☐	☐	w. Urinary tract infection	☐	☐
k. Hearing loss	☐	☐	x. Vertigo/dizziness	☐	☐
l. Heart disease	☐	☐	y. Visual correction – eyeglasses/contact lenses	☐	☐
m. Hernia	☐	☐	z. Visual problems – other	☐	☐

3. Has the applicant:	**Yes**	**No**
a. Had any surgical operation not revealed in question 2, or gone to a hospital, clinic, dispensary, or sanatorium for observation, examination, or treatment not revealed in question 2?	☐	☐
b. Taken any prescribed medication in the past six months?	☐	☐
c. ***Presented any history or current evidence of nervous, emotional, or mental abnormality, functional nervous breakdown, nervous fatigue, depression, suicide attempts, eating disorders, or antisocial behavior?**	☐	☐
d. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs?	☐	☐
e. Ever received treatment for or advice about a problem with alcohol or drug use, either from a physician/other practitioner or an organization that assists those who have an alcohol or drug problem?	☐	☐
f. Had excessive weight gain or loss recently?	☐	☐
g. Suffered chest pain, wheezing, shortness of breath, or fainting episodes?	☐	☐
h. Suffered chronic diarrhea, vomiting, abdominal pain, or constipation?	☐	☐
i. Exhibited chronic skin conditions (e.g., severe acne, eczema, psoriasis)?	☐	☐
j. Suffered weakness of neurological or muscular skeletal system?	☐	☐
k. Had any dietary restrictions? If yes, specify and note reason (medical, religious, personal choice):	☐	☐

If you answered "Yes" for any parts of questions 2 and 3, please explain:
Affirmative answers to questions 2b, 2f, 2q, and/or 3c require a letter of explanation from the treating physician.

Question (e.g., 2e)	**Nature and severity of disorder, diagnosis, frequency of attacks, prognosis, and treatment**	**Dates and duration**

Medical History and Examination, Page 2 of 2

Applicant Name

4. Will the applicant be bringing any prescribed medication on the exchange? ☐ **Yes** ☐ **No**

If yes, please list each medication, including the international and generic names, compound symbols, dosage, frequency, and reason for use:

Prescribed Medication	**Dose/Frequency**	**Reason for Use**

5. Indicate year when the applicant had the following infectious diseases (or indicate that he or she has not):

Measles (rubeola)	Mumps	Hepatitis	Whooping cough (pertussis)
Rubella (German measles)	Chicken pox	Scarlet fever	Other:

6. The applicant has been immunized against the following diseases (clearly state the dates of all doses received):

Immunizations are a prerequisite to school attendance in many locations. The host country or school may require additional immunizations.

Immunization	**Number of Doses**	**Dates of each dose** (e.g., 25/Jan/2006)	**Immunization**	**Number of Doses**	**Dates of each dose** (e.g., 25/Jan/2006)
Diphtheria			Measles (rubeola)		
Whooping cough (pertussis)			Polio (Sabin-3 or more TOPV, Salk-4 or more IPV)		
Tetanus			Hepatitis B		
Rubella (German measles)			Other (specify)		
Mumps					

Additional comments:

7. Tuberculosis screening: The applicant must present evidence of recent (within 3 months) Mantoux/PPD skin test.

Date of screening (*e.g.*, 25/Jan/2012)_____ _____ Result/diagnosis: _____ If a different test was administered or the applicant received a BCG vaccine, please explain methods and treatments used to obtain screening results:

Physical Examination

Height:	Weight:	Blood Pressure: Sys. Dia.	Pulse rate/minute:

8. Does today's examination show any abnormal findings for:

	Yes	No		Yes	No		Yes	No		Yes	No
Head and neck	☐	☐	Heart (murmur, pressure)	☐	☐	Extremities (muscular)	☐	☐	Abdomen (mass)	☐	☐
Ear, nose, throat	☐	☐	Hernias	☐	☐	Skeletal system	☐	☐	Rectal	☐	☐
Chest/lungs	☐	☐	Lymph nodes/breasts	☐	☐	Neurological	☐	☐	Skin	☐	☐
			Genitalia	☐	☐						

If yes, please provide detailed information on a separate page *(typed or computer-generated with the applicant's full legal name and date of birth at the top of each page)*.

CERTIFICATION

I certify that I hold a valid current license to practice medicine and am not an immediate relative of the patient, and that I have personally examined the applicant and reported my findings as noted above and the attached page(s) (if additional pages are attached, please check here: ☐).

I find the applicant:

☐ In good health and not suffering from any mental or medical condition(s) that would preclude participation in the Rotary Youth Exchange program.

☐ Suffering from mental or medical condition(s) as noted in my report that could impact his/her participation.

Additionally, I find the applicant in good health and not suffering from any condition(s) that would preclude participation in sporting/physical activities of the applicant's choice. ☐ Yes ☐ No

Physician's Name (type or print)	**Signature** (in blue ink)	**Date** *(e.g., 25/Jan/2012)*

Physician's address, phone, and fax (type or stamp)