STATES' 4-H INTERNATIONAL EXCHANGE PROGRAMS
2021 SUMMER OUTBOUND PROGRAM
MEDICAL FORM

Delegate's Name:_____ Date of Birth:_____
Month/Day/Year

Destination Country:_____ State:_____

This Medical Form must be completed by a parent or guardian

Context: The applicant is applying for a month-long cross-cultural exchange program. Delegates live either as a group or as a member of a family in a host country. 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. Sharing a complete medical history is vital in determining the best exchange opportunity for each youth. ***This form must be completed within one year of the date of departure.**

1. **Does the applicant have any allergies or reactions to drugs or non-drug items?**

Medicines:

Penicillin or Related Drugs: Yes ☐ No ☐

Aminopyrine or Sulpyrine Type Drug: Yes ☐ No ☐

Others:_____

Types and degree of reaction: _____

Non-Drug Items:

Bees ☐ Pollen ☐ Dogs ☐ Cats ☐ Small Animals ☐

Foods: _____

Other non-food items:_____

Types and degree of reaction:_____

2. **Is the applicant subject to any of the following? If YES, please explain condition and/or frequency in detail.**

		Condition/Frequency
Asthma/Respiratory Problems	Yes ☐ No ☐	
Diabetes/Hypoglycemia	Yes ☐ No ☐	
Heart 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 ☐	
Anxiety	Yes ☐ No ☐	
Depression	Yes ☐ No ☐	

Any Other Conditions (Please list and explain): _____

_____

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

		Remarks
Eyes	Yes ☐ No ☐	
Uses Contact Lenses	Yes ☐ No ☐	
Ears	Yes ☐ No ☐	
Nose	Yes ☐ No ☐	
Throat	Yes ☐ No ☐	
Digestion	Yes ☐ No ☐	
Sleepwalking	Yes ☐ No ☐	
Bed-Wetting	Yes ☐ No ☐	
Menstrual problems	Yes ☐ No ☐	

Any other Difficulties: (Please list)_____

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

_____

5. Are there any physical activities that the applicant is restricted from doing?
Yes ☐ No ☐ If YES, please list: _____

_____

6. If an applicant will be carrying medicines/prescriptions during the exchange, please fill in the following:

Name of Medicine	Illness/Symptoms	Dosage/Times Taken

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

_____

8. Is the applicant currently under a doctor's care (for reasons other than routine care)?
Yes ☐ No ☐ Explain:_____

_____

_____

_____

9. Any additional information the host parents should be aware of?
Yes ☐ No ☐ Explain:_____

_____

_____

_____

_____

10. Inoculation History - fill out below or attach vaccination records.

Vaccine	Number	Date of injection	Vaccinated by/at	Contracted?	Date contracted (M/D/Y)
Measles	1st ☐			Yes ☐ No ☐	
	2nd ☐				
Mumps	1st ☐			Yes ☐ No ☐	
	2nd ☐				
Rubella	1st ☐			Yes ☐ No ☐	
	2nd ☐				
Chickenpox	☐			Yes ☐ No ☐	
Polio (OPV)	1st ☐			Yes ☐ No ☐	
	2nd ☐				
	3rd ☐				
	4th ☐				
DPT Diphtheria Pertussis Tetanus	1st ☐			Yes ☐ No ☐	
	2nd ☐				
	3rd ☐				
	4th ☐				
	5th ☐				
Tuberculosis	☐			Yes ☐ No ☐	
Hepatitis B	1st ☐			Yes ☐ No ☐	
	2nd ☐				
	3rd ☐				
Others				Yes ☐ No ☐	

11. Considering the information provided above and your knowledge of the applicant, is there any reason to question his/her/their participation in this program?

Yes ☐ No ☐ Explain:_____

_____

For additional comments, please use an extra sheet of paper.

I certify that all information in this Medical Form is true and complete to the best of my knowledge. I further certify that if any medical information were to change after submission of this form, that I will notify States' 4-H of these changes as soon as possible.

_____ _____ _____

*Signature of legal guardian | Print name of legal guardian | Date