Sponsor District: 1410 Applicant Name: Ville Matias VUOSIVAIHTARI

Rotary Youth Exchange – Long-Term Exchange Program

Section C-1: Medical History & Examination

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.

Fill in personal data

tary Sponsor District Instructions for required copies and signatures. Print specified number of completed copies]). Electronic signature may be applied last if both paper and electronic signatures are needed.

Full Legal Name as on passport or birth certificate *(use uppercase for FAMILY name; e.g. John David SMITH)*	Date of Birth (YYYY-MM-DD)	☒ Male ☐ Female ☐ Non-Binary
Ville Matias VUOSIVAIHTARI	2007-07-09	

Home Address – Street	City	State/Province	Postal Code	Country
Vuosivaihtotie 1	Salo		24280	Finland

E-mail Address	Home Phone Number	Mobile Phone Number
torsti.poutanen@kolumbus.fi		+358401234567

Medical History

Medical Doctor fills from here on

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. Vision 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 (except non-medical dietary restrictions):
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**

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Rotary Youth Exchange – Long-Term Exchange Program

Section C-1: Medical History & Examination

4. Indicate year when the applicant had the following infectious dseases (or indicate that he or she has not). Use Part 5 comments for other details.

Measles (rubeola) ☐ No ☐ Yes, year _____	Mumps ☐ No ☐ Yes, year _____	Hepatitis (if so, see comments) ☐ No ☐ Yes, year _____	Whooping cough (pertussis) ☐ No ☐ Yes, year _____
Rubella (German measles) ☐ No ☐ Yes, year _____	Varicella (Chicken Pox) ☐ No ☐ Yes, year _____	Scarlet fever ☐ No ☐ Yes, year _____	Other: COVID-19 ☐ No ☐ Yes, year _____

5. Immunization Information ***(may be completed by medical records, nursing or appropriate personnel and verified by physician)***

Please verify that these ISO format dates match the official source documents provided in "Section C-2: Immunization Records/Certification copies"

The applicant has been immunized against the following diseases:	**Dates of immunizations** *Using ISO format (YYYY-MM-DD) enter the dates of ALL doses received. Immunizations are a prerequisite to school attendance in many locations. Requirements vary. The host country, host Rotary district and/or school may require additional immunizations .*						
	1st	2nd	3rd	4th	5th	6th	7th
Diphtheria							
Pertussis (whooping cough)							
Tetanus							
Rubella (German measles)							
Mumps							
Measles (rubeola)							
Polio ☐ Sabin TOPV (3 or more) ☐ Salk IPV (4 or more)							
Varicella (Chicken Pox/Shingles)							
Hepatitis B							
Hepatitis A							
Yellow Fever							
Japanese Encephalitis							
Meningococcal Meningitis							
Typhoid							
COVID-19 Manufacturer or Name:							
Others (specify):							
Additional Comments: *(Examples: Other COVID-19 vaccine manufacturer(s) for later doses, hepatitis lab test results, other immunizations, vaccine adverse reactions)*							

6. Tuberculosis screening: The applicant must present evidence of recent TB screening (within 3 months of examination date) by skin test or blood test.

Date of screening (YYYY-MM-DD) _____ Result/diagnosis: _____ Method: ☐ TB Skin test (TST) ☐ TB Blood test (IGRA)

Please document any BCG vaccine dose(s), diagnostic studies or treatments related to tuberculosis not included in above immunizations or comments.

If no tuberculosis screening done, leave this part BLANK

Tuberculosis screening is done only if requested by Rotary.

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Section C-1: Medical History & Examination

7. 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

Physical Examination

Date: (yyyy-mm-dd)	Height: (cm)	Weight: (kg)	Blood Pressure: Systolic (mmHg) Diastolic	Pulse: (rate/minute)

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

	Yes	No		Yes	No		Yes	No		Not done	Yes	No
Head and neck	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Breasts	☐	☐	☐
Ear, nose, throat	☐	☐	Hernias	☐	☐	Extremities	☐	☐	Genitalia (external)	☐	☐	☐
Chest/lungs	☐	☐	Lymph nodes	☐	☐	Spine/Skeletal	☐	☐	Rectal	☐	☐	☐
Heart	☐	☐				Neurological	☐	☐				

Not done (See below)

Examination of Breasts and External Genitalia is at physician discretion. Rectal exam is not required if bowel history and abdominal exam are normal.

For any "YES" (abnormal) in part 8, above, please note details in the space below with any other comments or recommendations.

If more space is needed, please provide on separately signed typewritten or computer-generated page(s) with applicant's full name and date of birth.

OTHER notes: Physical Examination findings, comments or recommendations, if any:

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: Make sure that the Medical Doctor ticks relevant boxes.

☐ 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 address, phone, fax and E-mail

Medical Doctor stamps here

Physician Name

Physician Signature (ink on paper) or basic e-signature (using Fill & Sign)

Medical Doctor signs and dates here

Date (YYYY-MM-DD)

If there are separate pages, including any Letter(s) of explanation from treating physician(s), please append following this page.