



# 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.

*Use computer entry if possible. Consult Rotary Sponsor District Instructions for required copies and signatures. Print specified number of completed copies first for ink signatures on paper (if required). Electronic signature(s) 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
Home Address – Street		City	State/Province	Postal Code
E-mail Address		Home Phone Number		Mobile Phone Number
				Country

### 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		No	
a. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	n. Liver disease/hepatitis	<input type="checkbox"/>	
b. <b>Anorexia/bulimia/other eating disorder*</b>	<input type="checkbox"/>	<input type="checkbox"/>	o. Malaria	<input type="checkbox"/>	
c. Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	p. Menstrual disorders	<input type="checkbox"/>	
d. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<b>q. Mental disorders*</b>	<input type="checkbox"/>	
e. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	r. Pneumonia	<input type="checkbox"/>	
f. <b>Attention deficit disorder*</b>	<input type="checkbox"/>	<input type="checkbox"/>	s. Rheumatic fever	<input type="checkbox"/>	
g. Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	t. Serious headache/migraine	<input type="checkbox"/>	
h. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	u. Stomach ulcer	<input type="checkbox"/>	
i. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	v. Typhoid fever	<input type="checkbox"/>	
j. Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	w. Urinary tract infection	<input type="checkbox"/>	
k. Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	x. Vertigo/dizziness	<input type="checkbox"/>	
l. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	y. Visual correction – eyeglasses/contact lenses	<input type="checkbox"/>	
m. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	z. Visual problems – other	<input type="checkbox"/>	
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?				<input type="checkbox"/>	<input type="checkbox"/>
b. Taken any prescribed medication in the past six months?				<input type="checkbox"/>	<input type="checkbox"/>
c. <b>*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?</b>				<input type="checkbox"/>	<input type="checkbox"/>
d. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs?				<input type="checkbox"/>	<input type="checkbox"/>
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?				<input type="checkbox"/>	<input type="checkbox"/>
f. Had excessive weight gain or loss recently?				<input type="checkbox"/>	<input type="checkbox"/>
g. Suffered chest pain, wheezing, shortness of breath, or fainting episodes?				<input type="checkbox"/>	<input type="checkbox"/>
h. Suffered chronic diarrhea, vomiting, abdominal pain, or constipation?				<input type="checkbox"/>	<input type="checkbox"/>
i. Exhibited chronic skin conditions (e.g., severe acne, eczema, psoriasis)?				<input type="checkbox"/>	<input type="checkbox"/>
j. Suffered weakness of neurological or muscular skeletal system?				<input type="checkbox"/>	<input type="checkbox"/>
k. Had any dietary restrictions? If yes, specify and note reason (medical, religious, personal choice):				<input type="checkbox"/>	<input type="checkbox"/>
If you answered "Yes" for any parts of questions 2 and 3, please explain (except non-medical dietary restrictions):					
<i>*Affirmative answers to questions 2b, 2f, 2q, and/or 3c require a letter of explanation from the treating physician</i>					
Question (e.g., 2e)	Nature and severity of disorder, diagnosis, frequency of attacks, prognosis, and treatment			Dates and duration	



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4. Indicate year when the applicant had the following infectious diseases (or indicate that he or she has not). Use Part 5 comments for other details.			
Measles (rubeola) <input type="checkbox"/> No <input type="checkbox"/> Yes, year _____	Mumps <input type="checkbox"/> No <input type="checkbox"/> Yes, year _____	Hepatitis (if so, see comments) <input type="checkbox"/> No <input type="checkbox"/> Yes, year _____	Whooping cough (pertussis) <input type="checkbox"/> No <input type="checkbox"/> Yes, year _____
Rubella (German measles) <input type="checkbox"/> No <input type="checkbox"/> Yes, year _____	Varicella (Chicken Pox) <input type="checkbox"/> No <input type="checkbox"/> Yes, year _____	Scarlet fever <input type="checkbox"/> No <input type="checkbox"/> Yes, year _____	Other: <input type="checkbox"/> No If Yes, explain:

5. Immunization Information <i>(may be completed by medical records, nursing or appropriate personnel and verified by physician)</i>							
Please provide or confirm a copy of the student's original immunization record(s) in addition to completing this information section. ( See Section C-2. )							
The applicant has been immunized against the following diseases:	Dates of immunizations <i>(clearly state the dates of ALL doses received – YYYY-MM-DD)</i> <i>Immunizations are a prerequisite to school attendance in many locations. Requirements vary.</i> <i>The host country, host Rotary district and/or school may require additional immunizations.</i>						
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>	7 <sup>th</sup>
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):							
<b>Additional comments:</b> (Examples: hepatitis lab test results, other immunizations, vaccine adverse reactions)							

6. Tuberculosis screening: The applicant must present evidence of recent (within 3 months) Mantoux/PPD skin test.
Date of screening (YYYY-MM-DD) _____ 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:



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**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

Height: (cm)	Weight: (kg)	Blood Pressure:    Sys.                      Dia. (mmHg)	Pulse rate/minute:
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**8. Does today's examination show any abnormal findings for:**

	Yes	No		Yes	No		Yes	No
<b>Head and neck</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Heart</b> (murmur, pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Extremities</b> (muscular)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ear, nose, throat</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hernias</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Skeletal system</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chest/lungs</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymph nodes/breasts</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurological</b>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Genitalia</b>	<input type="checkbox"/>	<input type="checkbox"/>			

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 address, phone, fax and E-mail (type or stamp)	Physician Name (type or print)
	Physician Signature (ink on paper) or basic e-signature (using Fill & Sign); click only for digital signature
	Date (YYYY-MM-DD)

### Parent and Applicant Declaration:

We/I hereby confirm:

- (1) that the Medical Section C and Dental Section D include ALL the medical information known to us/me. Incomplete Medical or Dental Sections may lead to an early termination of the exchange.
- (2) that the exchange student will be fully vaccinated according to the requirements of the receiving host country, host Rotary district or school.
- (3) that if additional medical issues arise between the completion of this application form and the exchange departure date, sponsor and host districts will be notified immediately.
- (4) I further authorize the Rotary Youth Exchange Officer, the Rotarian Counselor and/or the host parents to serve as my child's/my representative for the purpose of receiving medical information and communicating with medical providers about my child's/my medical condition.

<b>Parent/Legal Guardian #1 Signature:</b> Name: Date:	<b>Applicant Signature:</b> Name: Date:
<b>Parent/Legal Guardian #2 Signature:</b> Name: Date:	This form provides for authenticated digital signatures by clicking on signature fields. Basic electronic signatures are applied instead using Fill & Sign Tool <u>without clicking on signature field</u> . Leave signature fields empty to print and apply ink signature for scanned copies. Doing all signatures the same way is usually best, but ink and basic electronic signatures can be mixed. <b>Follow RYE Sponsor District instructions</b> regarding suitable signatures for this application.

*Letter(s) of explanation from treating physician(s), if any, and separate pages for any abnormal physical findings are to be appended following this page.*