**Sponsor District:** _____ **Applicant Name:** _____

# 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 | Country |
| | | | | |

| E-mail Address | Home Phone Number | Mobile Phone Number |
|---|---|---|
| | | |

## 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): ( none ) | ☐ | ☐ |

**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** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Sponsor District: _____ Applicant Name: _____

# Rotary Youth Exchange – Long-Term Exchange Program

## Section C-1: Medical History & Examination



| 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) ☐ 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** *(clearly state the dates of ALL doses received in ISO format (YYYY-MM-DD) 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*

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Sponsor District: _____ Applicant Name: _____

# Rotary Youth Exchange – Long-Term Exchange Program

## 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 | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Head and neck | ☐ | ☐ | Heart (murmur, rhythm) | ☐ | ☐ | Extremities (muscles) | ☐ | ☐ | Abdomen (mass) | ☐ | ☐ |
| Ear, nose, throat | ☐ | ☐ | Hernias | ☐ | ☐ | Skeletal system | ☐ | ☐ | Skin | ☐ | ☐ |
| Chest/lungs | ☐ | ☐ | Lymph nodes/breasts | ☐ | ☐ | Neurological | ☐ | ☐ | Rectal ☐ Not done (See below) | ☐ | ☐ |
| | | | Genitalia (external) | ☐ | ☐ | | | | | | |

Rectal exam is not required if bowel history and abdominal exam are normal. For any "YES" (abnormal) in part 8, above, 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 | Physician Name |
|---|---|
| | **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 Sections C-1 and C-2 with Dental Section D include ALL the health 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.

| | |
|---|---|
| **Parent/Legal Guardian #1 Signature:**<br>**Name:**<br>**Date:** | **Applicant Signature:**<br>**Name:**<br>**Date:** |
| **Parent/Legal Guardian #2 Signature:**<br>**Name:**<br>**Date:** | This form provides for authenticated digital signatures by clicking on signature fields. Basic electronic signatures are applied instead using Fill & Sign Tool without clicking on signature field. 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. **Follow RYE Sponsor District instructions** 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.***