Oregon 4-H Youth Development Program
MEDICAL FORM (Minor)
- to be completed by physician

Participant's Name:_______________________________ State:____________

Destination Country: _______________________________ Date of Birth:____________________
Month/Day/Year

Name of Japanese Organization (for Japan program only):____________________

To the Examining Physician: This individual is applying for a cross-cultural exchange program. Participants live 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. Your careful and complete evaluation of the applicant's health will be helpful in determining his/her assignment. If the applicant is accepted for participation, necessary immunizations will be required.

1. **Inoculation History**

Vaccine	Number	Date of injection	Vaccinated by/at	Contracted or not?	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					
Vaccine type for TB					
Hepatitis B	1st				
	2nd				
	3rd				
Others					

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2. Is this person subject to any of the following? If YES, please explain condition and/or frequency.

			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	__________

Any Other Disorder (Please list and explain)

____

____

3. Does he/she 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:____________________

- **Non-Drug Items:**
  - Bees Pollen, Dogs Cats Small Animals
  - Foods____________________

4. Does he/she 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)____________________

- Any surgical operations, accidents, or injuries which required hospitalization in the past?

  Yes No Explain: ______________________________

- Any recent exposure to a contagious disease?

  Yes No Explain: ______________________________

- If applicant is carrying medicines/prescriptions, fill in the following. Put "P" for prescriptions.

Name of medicine	For what illness/symptoms	Dosage/Times taken

- Are there any physical activities that applicant is restricted from doing? If YES, please list.

  Yes No If so, what kind? ______________________________

- Any additional information the host parents should be aware of?

  Yes No Explain: ______________________________

- Is this person currently under a doctor's care?

  Yes No Explain: ______________________________

- Considering the statements above, your examination, and any information you may have provided in connection with the above questions, is there any reason you would question this applicant's participation in this program?

  Yes No Explain: ______________________________

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

Date of examination upon which this report is based: ______________________________

I have given a thorough physical examination and reviewed the medical history of the candidate. I certify that all important medical information has been included and that the above information is complete and accurate.

Physician's Name/Address	**Physician's official stamp and signature**
______________________________ ______________________________ Date: Month/Day/Year ____________________	

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