# MEDICAL HISTORY AND INFORMATION OF STUDENT

Student's First Name:_____ Student's Last Name:_____

_____

**The applicant must have a physical examination by a licensed doctor, who is not a family member, within one year of the program start date. The physician should complete this report of the applicant's medical history and current health.**

| | YES | NO |
|---|---|---|
| 1/ How long have you known/treated the applicant? _____ year(s) | | |
| 2/ Are you the applicant's regular doctor? | ○ | ○ |
| 3/ Is the applicant currently under treatment for any physical or mental conditions? If yes, please explain: | ○ | ○ |
| 4/ Is the applicant currently taking any medication? If yes, please list medications and their purpose: | ○ | ○ |
| 5/ Will the applicant be taking medication while on exchange? If yes, please list medications and their purpose: | ○ | ○ |
| 6/ Has the applicant had restriction of a physical activity in the past year? If yes, please explain: | ○ | ○ |
| 7/ Has the applicant had any treatment or counselling for a nervous condition, personality disorder, or mental health issue? If yes, please explain: | ○ | ○ |
| 8/ Has the applicant been hospitalized or had surgery in the past year? If yes, please explain: | ○ | ○ |
| 9/ Has the applicant been advised to have surgery which has not yet been done? If yes, please explain: | ○ | ○ |

**Does the applicant currently have or had a history of the following illnesses or symptoms? If *yes*, please check box and provide further information on the following page.**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Allergies to drugs, foods, etc. | ○ | ○ | Eating Disorder | ○ | ○ | Pneumonia | ○ | ○ |
| Anxiety Disorder | ○ | ○ | Enuresis (bed wetting) | ○ | ○ | Psoriasis/Eczema | ○ | ○ |
| Appendicitis | ○ | ○ | Epilepsy | ○ | ○ | Rheumatic Fever | ○ | ○ |
| Has Appendix been removed? | ○ | ○ | Headache/Migraine (persistent) | ○ | ○ | Seizure Disorder | ○ | ○ |
| Asthma | ○ | ○ | Hepatitis Type | ○ | ○ | Sleep Disorder | ○ | ○ |
| Behavioral Disorder | ○ | ○ | Hernia | ○ | ○ | Thyroid Disorder | ○ | ○ |
| Celiac Disease | ○ | ○ | Insect Bite Sensitivity | ○ | ○ | Ulcerative Colitis | ○ | ○ |
| Cough (persistent, recurring) | ○ | ○ | Learning Disability | ○ | ○ | Vertigo, Dizziness | ○ | ○ |
| Crohn's Disease | ○ | ○ | Menstrual Disorder | ○ | ○ | Other: | ○ | ○ |
| Depression | ○ | ○ | Mental Illness | ○ | ○ | | ○ | ○ |
| Diabetes | ○ | ○ | Mononucleosis | ○ | ○ | | ○ | ○ |

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**If *yes* for any of the above, please provide in detail each allergy, disorder, illness, etc. as well as any medications required for treatment. If needed, please use a separate sheet of paper, also to be signed, stamped, and dated.**

| **Doctor's Name:** | **Signature/Seal:** | **Date:** |
|---|---|---|
| | | _____ / _____ / _____<br>MM DD YYYY |