



Rotary Youth Exchange – Long-Term Exchange Program

Section C-1: Medical History & Examination

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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 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. 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 attack, 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) 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: No Yes, year _____

5. Immunization Information <i>(may be completed by medical records, nursing or appropriate personnel and verified by physician)</i>						
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 or pathogens:	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. DATES OF ALL IMMUNIZATIONS: Enter the dates of ALL doses using ISO format (YYYY-MM-DD).					
	Dose 1 DATE	Dose 2 DATE	Dose 3 DATE	Dose 4 DATE	Dose 5 DATE	Dose 6 DATE
Pneumococcal (any type)						
Polio Sabin OPV (3 or more) Salk IPV (4 or more)						
Diphtheria						
Pertussis (Whooping Cough)						
Tetanus						
Hib (<i>H. influenzae</i> type b)						
Hepatitis B						
Hepatitis A						
Measles (Rubeola)						
Mumps						
Rubella (German measles)						
Varicella (chicken pox/shingles)						
Meningitis (meningo A,C,W,Y)						
Meningitis B (meningo B)						
Yellow Fever						
Japanese Encephalitis						
Typhoid						
COVID-19						
Other (specify):						
Other (specify):						
Other (specify):						
Other (specify):						
Additional Comments (Examples: additional dose dates, vaccine adverse reactions, vaccine manufacturer(s) for specific doses, hepatitis or other lab test results, other immunizations and dates)						

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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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)
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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:

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
	Date (YYYY-MM-DD)

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