

Medical Form Part A

(to be completed by applicant and reviewed by doctor)

Complete all questions and take a copy of your completed forms (Part A and B) with you on your trip abroad. The doctor completing this form may not be a relative.



Applicant's name: _____

Tick the appropriate boxes if you presently suffer from or ever had:

<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhus <input type="checkbox"/> Anaemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal disease <input type="checkbox"/> Herpes (cold sores) <input type="checkbox"/> kidney disease <input type="checkbox"/> Malaria	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> German measles <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Diphtheria <input type="checkbox"/> Tetanus <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Polio	<input type="checkbox"/> Eye problems <input type="checkbox"/> Heart disease <input type="checkbox"/> menstrual problems <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Epilepsy/Convulsions <input type="checkbox"/> Pregnancy/Miscarriage or Termination <input type="checkbox"/> Hernia <input type="checkbox"/> Varicose veins	<input type="checkbox"/> Asthma <input type="checkbox"/> Ear infection <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Bulimia <input type="checkbox"/> Anorexia <input type="checkbox"/> Depression <input type="checkbox"/> sleep walking <input type="checkbox"/> Diabetes	<input type="checkbox"/> glandular fever <input type="checkbox"/> Migraines/headaches <input type="checkbox"/> Dizziness / Fainting Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> other: _____ _____
---	---	--	--	--

If you have ticked any of the above, give details including dates:

For the program you need to be immune to Measles, Mumps, German Measles (Rubella), Chicken Pox and Whooping Cough by immunization or after having had this disease. You also need to have been vaccinated against Tetanus and Diphtheria within the last 10 years. Please indicate which disease you still need to get vaccinated for:

Other than to complete this medical form or for routine exams, have you visited the doctor or been hospitalized within the last 12 months, if yes, why?

Have you ever received counselling and /or medication for a nervous problem, eating disorder, depression or emotional problem?

Yes No If yes, give details and dates: _____

Have you ever been a victim of sexual, emotional or physical abuse? Yes No If yes, give details and dates:

Do you have any food allergies? Yes No If yes, please specify:

Do you have any allergies to animals? Yes No If yes, please specify:

Do you have any allergies to medications? Yes No If yes, please specify:

Do you have any other allergies Yes No If yes, please specify:

Do you have any habits which may affect your health (e.g. alcohol, cigarettes, drugs)? Yes No

Is your physical ability restricted in any way? Yes No

Do you carry any infectious diseases such as Hepatitis or the HIV virus in your blood? Yes No

Are you currently taking any medication? Yes No If yes, please specify: _____

Do you have any chronic or recurring illnesses? Yes No If yes, please specify: _____

I understand and agree that host families may have access to this medical form and I give permission to the doctor completing Part B to review all my responses in Part A and to provide or discuss additional information, if requested to do so by AIFS.

Should an emergency arise, I authorize any medical provider to release information regarding my condition to AIFS, their partners or their insurance provider / emergency assistance services and understand that they can contact my next kin, without prior consent.

The above information is correct to the best of my knowledge and I hereby give permission for emergency medical care to take place should it be necessary. I also understand that withholding or falsifying any information may result in me being withdrawn from the program.

Signature _____

Date _____

Medical Form Part B

(to be completed by doctor)



Applicant's name: _____

How long have you known the applicant? _____

Are you related to the applicant? Yes No (relatives may not complete this form)

Please review the information provided in Part A and give your opinion of the applicant's general state of health:

Excellent Good Fair Poor

Immunizations

Please ensure that the applicant is currently immune to the following (by vaccination or after the illness):

Measles:	Date of vaccination: _____	/	Date of illness: _____
Mumps:	Date of vaccination: _____	/	Date of illness: _____
German Measles (Rubella)	Date of vaccination: _____	/	Date of illness: _____
Chicken Pox:	Date of vaccination: _____	/	Date of illness: _____
Diphtheria	Date of vaccination: _____		
Tetanus	Date of vaccination: _____		
Whooping Cough	Date of vaccination: _____	/	Date of illness: _____

Immunity to Whooping Cough after the illness needs to be proven by blood test.
Date of positive blood test: _____

Please also indicate whether the applicant has been immunized against the following:

Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Tuberculosis(TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Typhoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____

General Health

Tick the appropriate box if there are any abnormalities to the following systems:

<input type="checkbox"/> Ear, nose and throat	<input type="checkbox"/> Eyes	<input type="checkbox"/> Neuropsychiatric	<input type="checkbox"/> Metabolic
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Skin	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Brain, nervous system	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Respiratory system/lungs	<input type="checkbox"/> Other

If you have ticked any of the above, please give details and dates: _____

Emotional Health

Is the applicant currently or has ever been treated /counseled or received medication for a nervous condition, eating disorder, depression or emotional problem? Yes No

If yes, give details and dates and comment on the applicant's present emotional well being: _____

Does the applicant have any history of physical, emotional or sexually related problems (i.e. abuse)? Yes No

If yes, please comment: _____

Contagious Diseases

Is the applicant, to the best of your knowledge, a likely carrier of any infectious disease such as Hepatitis B or C, or the HIV virus? (The applicant does not need to be tested) Yes No

Has the applicant been hospitalized for more than three days? Yes No

If you have ticked yes above, please give details and dates, if applicable: _____

Please use this space to give any additional relevant information: _____

Name of Doctor: _____

Address: _____ Telephone No.: _____

Signature and practice stamp: _____ Date: _____