International Partners Cassie Stern Memorial, Inc.

PHYSICIAN'S REPORT

Dear Physician: **It is of crucial importance that you give us your careful, candid, and complete evaluation of this applicant's health.** The International Partners program involves a challenging exercise in cross-cultural adjustment that includes a period of living as an active, contributing member of a group living abroad, plus several days of travel. To succeed, this applicant must have a **high degree of motivation and the ability to adjust to people of different social and cultural backgrounds**---sometimes under difficult circumstances. Because of this, **sound health** is an important asset for the participant. (Health issues do not necessarily preclude acceptance.) This is a brief summary of the program and is not designed to be all-inclusive. **Incomplete reports cannot be accepted and will be returned. Reports must be submitted on this form.**

Applicant's Name _____ **Date of Exam** _____
(within last year)

Information Required for Acceptance

MMR (measles, mumps, rubella) 1st vaccination date _____ 2nd vaccination date _____
TB (tuberculosis) current test (must be within last year) date _____ Result ___negative ___positive
If your TB test is positive, current chest x-ray results are required (within last year) _____

1-Is applicant seriously underweight or overweight? ___Yes ___No
2-Has applicant ever had any dietary restrictions or eating disorders, such as anorexia or bulimia? ___Yes ___No
3-Does applicant have any allergies (including allergies to vaccines, medications, plants, foods, animals)? ___Yes ___No
If yes, please explain _____
4-If applicant has allergies, is there a history of asthma, anaphylaxis, or other dangerous allergic conditions? ___Yes ___No
5-Is applicant currently under medical or psychological treatment? ___Yes ___No
6-Does applicant have any speech, hearing, eyesight, or physical (e.g., wheelchair, leg braces) impairment? ___Yes ___No
7-Is there any history of behavior disorders or emotional disturbances, such as difficulties in relationship with authority figures or peers, or abnormally severe mood swings? ___Yes ___No
8-Is there any congenital malformation or chronic condition now existing that may require additional treatment? ___Yes ___No
9-Would carrying his or her own luggage, or strenuous travel, cause applicant hardship? ___Yes ___No
10-Does applicant have any menstrual difficulties that might limit her participation in an active program? ___Yes ___No

I AGREE THAT THIS APPLICANT IS HEALTHY ENOUGH TO PARTICIPATE IN THIS PROGRAM ___Yes ___No

For what issues and situations have you seen the applicant in your office during the past five years? Please give dates. Please list any medication this applicant is currently taking, or include in a separate document stapled to this form.

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*If you answered "yes" to any of the 10 questions above and in your professional judgment, the facts or circumstances could materially impact the applicant's successful participation in a challenging program, please complete the attached Secondary Medical Review Form.

Height_____ Urine: Sugar_____ Protein_____ Blood pressure_____ Pulse_____ Weight_____
Eyes: Are glasses worn?_____ Are contacts worn?_____ Ears: Is hearing normal?_____ Are drums intact?_____

Are there any abnormalities of the following systems?

	Yes	No		Yes	No		Yes	No		Yes	No
Nose and throat	_____	_____	Orthopedic problems (frequent backaches)	_____	_____	Heart Murmur	_____	_____	Lungs	_____	_____
Chest	_____	_____				Abdomen (scars, hernia, etc.)	_____	_____	Teeth	_____	_____
Neck (thyroid, enlarged nodes, etc.)	_____	_____	Skin (acne, etc.)	_____	_____				Gums	_____	_____
			Tonsils	_____	_____	Neurological	_____	_____	Heart	_____	_____

Women: Breast exam (optional)_____ Pelvic Exam (optional)_____ Pap smear (optional)_____
Menarche _____ Dysmenorrheal_____ Medication(s)_____

Physician's signature _____ Date _____
Physician's Name _____ Telephone_____
Physician's Address_____
_____
City State Zip