

International Partners, Cassie Stern Memorial, Inc.

2007-2008 MEDICAL FORM

To be completed by applicant's custodial parent, legal guardian, or applicant (*if 18 years of age or over*):

- Reports must be submitted on this form. Other forms will not be accepted.
- This report must be based on a physical examination given since June 1, 2007. Please make sure you and your physician have fully completed, signed, and dated this form. Incomplete reports cannot be accepted and will be returned.
- We cannot accept medical forms that have been completed by a physician who is related to you.

Name of applicant _____
last first middle

Mailing address _____

city state zip code

Home telephone _____ Date of birth _____
area code month/day/year

The applicant **has** The applicant **has not**
been under treatment or counseling for a significant condition in the last five years. I will inform International Partners of any new treatment prior to the start of the program. By signing this, you agree to these conditions of participation.

Country/Program Code _____

Applicant signature _____ Date _____

Custodial parent's or
Legal guardian's signature _____ Date _____
(if applicant is under 18)

Participation is contingent upon the International Partners' review of the student's completed medical forms. Failure to disclose complete and accurate information on the medical form can result in dismissal from the program. International Partners normally requires that all students participating in international programs show medical and psychological stability, as determined by International Partners, for no less than six months prior to the group's departure date.

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 name _____ Date of exam _____
(After June 1, 2007)

Information Required for Acceptance

MMR (*measles, mumps, rubella*) 1st vaccination date _____ 2nd vaccination date _____
 TB (*tuberculosis*) current test (*must be since June 1, 2007*) date _____ Result: negative positive
If your TB test is positive, current chest x-ray results are required (*since June 2007*) _____

1. Is this applicant seriously underweight or overweight? _____ yes _____ no
 2. Has this applicant ever had any dietary restrictions or eating disorders, such as anorexia or bulimia? _____ yes _____ no
 3. Does this applicant have any allergies (including allergies to vaccines, medications, plants, foods, animals)? _____ yes _____ no
 If yes, please explain. _____
 4. If this applicant has allergies, is there a history of asthma, anaphylaxis, or other dangerous allergic conditions? _____ yes _____ no
 5. Is this applicant currently under medical or psychological treatment? _____ yes _____ no
 6. Does this 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 the applicant hardship? _____ yes _____ no
 10. Does this applicant have any menstrual difficulties that might limit her participation in an active program? _____ yes _____ no
- ____ yes ____ no **I AGREE THAT THE APPLICANT IS HEALTHY ENOUGH TO PARTICIPATE IN THIS PROGRAM.**

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 student is currently taking.

If you answered "yes" to any of the above 10 questions 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		Heart Murmur		Lungs
	Chest		(<i>frequent backaches?</i>)		Abdomen (<i>scars,</i>		Teeth
	Neck (<i>thyroid, enlarged</i>		Skin (<i>acne, etc.</i>)		<i>hernia, etc.</i>)		Gums
	<i>nodes, etc.</i>)		Tonsils		Neurological Problems		Heart

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

Physician's signature _____ Date _____

Physician's Name _____ Telephone _____
area code

Physician's Address _____

city

state

zip code