PHYSICIAN'S STATEMENT OF HEALTH

THIS PAGE MUST BE COMPLETED AND CONFIRMED BY THE EXAMINING PHYSICIAN. PLEASE ANSWER ALL QUESTIONS.

Name of patient:_____

Date of Birth (mm/dd/yyyy) _____/_____/_____ ☐ Male ☐ Female

Does the patient have any of the following? If yes, give date of illness and detailed information regarding any impairment in the space provided below.

	Yes	No	Year		Yes	No	Year
Chicken pox	☐	☐		Allergies*	☐	☐	
Measles	☐	☐		Asthma*	☐	☐	
Mumps	☐	☐		Appendicitis	☐	☐	
Poliomyelitis	☐	☐		Cough (persistent, recurring)	☐	☐	
Rheumatic Fever	☐	☐		Diabetes Mellitus	☐	☐	
Rubella	☐	☐		Enuresis	☐	☐	
Scarlet Fever	☐	☐		Thyroid abnormality (Struma)	☐	☐	
Malaria	☐	☐		Headache (persistent, recurring)	☐	☐	
Hepatitis	☐	☐		Hernia	☐	☐	
Parasites (intestinal, other)	☐	☐		Learning or Speech Defect	☐	☐	
Seizure Disorder	☐	☐		Vertigo, Dizziness	☐	☐	
Sleepwalking	☐	☐		Other (please indicate)_____	☐	☐	

** If yes, physician must attach statement describing allergy, allergen, medication sensitivity, symptoms, treatment, medications and expected future treatment.*

Any disease, impairment or abnormality of any of the following:

	Yes	No	Year		Yes	No	Year
Abdominal Organs, Digestive System	☐	☐		Eyes or Vision	☐	☐	
Bones, Joints, Locomotor System	☐	☐		Genito-Urinary System	☐	☐	
Blood, Endocrine System	☐	☐		Heart or Blood Vessels	☐	☐	
Brain, Nervous System	☐	☐		Lungs, Respiratory System	☐	☐	
Ears or Hearing	☐	☐		Skin (Acne, etc.)	☐	☐	
Eating Disorders	☐	☐		Tonsils, Nose or Throat	☐	☐	
Emotional/Behavioral Problems	☐	☐		Varicose Veins	☐	☐	

Will patient be using any prescription drugs/medication while in the U.S. ? ☐ Yes ☐ No
Has patient ever been hospitalized? ☐ Yes ☐ No
Has patient ever consulted a neurologist? ☐ Yes ☐ No
Has patient ever consulted a psychologist? ☐ Yes ☐ No
Has patient ever consulted any other kind of specialist? ☐ Yes ☐ No

If yes, to any of the above, please give details in English: _____

_____

_____

_____

Physicians Signature:_____ Date:_____

MEDICAL INFORMATION AND IMMUNIZATION RECORD

Name of patient:_____

Date of Birth (mm/dd/yyyy) _____/_____/_____

Give your opinion of the general state of the candidate's health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Blood group: ☐ A ☐ B ☐ AB ☐ 0
Rh factor: ☐ Rh positive ☐ Rh negative

If the patient wears glasses or contact lenses, please complete the following ophthalmic information:

	Sphere	Cylinder	Axis	Prism	Base
(OD) Ocular Dexter					
(OS) Ocular Sinister					

CURRENT T.B. EXAMINATION

Must have been completed within the last three (3) years.

B.C.G. Vaccination (mo/year): _____ / _____
If BCG Vaccination given, chest X-ray results must be provided.

TB Skin Test Date (mo/year): _____ / _____ Results: ☐ Negative ☐ Positive
If positive, chest X-ray results must be provided.

Subject: Results of Chest X-ray – examination date (mo/year): _____ / _____

IMMUNIZATION

Please put the date of the most recent booster. Important: for DT and Polio is mandatory every 10 years.

VACCINE	Most Recent Dose Given Month / Year
DTP and/or DT (Diphteria,Tetanus and Pertussis) or (Wooping cough) or (Tetanus and Diphiteria only)	_____ / _____
Polio Myelitis	_____ / _____
Measles (Rubeola -10 days measles)	_____ / _____
Rubella (German Measles – 3 day measles)	_____ / _____
Mumps	_____ / _____

I, the undersigned, have given a thorough physical examination and reviewed the medical history of the candidate and certify that all important medical information has been included and that the above information is accurate.

Physician's Name (type or print): _____

Address: _____

Physician's Signature: _____ Date: _____

Stamp or Physician's #: _____

Signature of Participant: _____ Date: _____