iE – USA Program
Medical History and Physical Examination

_____ ☐ male ☐ female Date of birth: _____
Full legal name of student mes/día/año

For the Physician:

This student is considering to study abroad as an exchange student. Insufficient, inadequate or improper information about the student relative to medications, psychiatric, psychological, or other medical problems could put the life of the student in danger while overseas. Allergy information in particular is critical to school and host family placement and the student's safety and wellbeing. This Medical History and Examination may not be completed by an immediate relative of the student.

Este estudiante está siendo evaluado como estudiante de intercambio. Información insuficiente, inadecuada o no exacta sobre sus medicaciones, psiquiatría, su condición psicológica o cualquier otro problema médico puede poner en serio peligro la vida del estudiante durante su estancia en el extranjero. La información relativa a alergias is de máxima importancia para el colegio y la familia de acogida así como para conformar una estancia segura y apropiada. Este informe médico no puede ser certificado por ningún pariente directo del estudiante.

1. Has the student ever received treatment or advice from a physician or other practitioner for:

		YES	NO
a.	A.D.D./A.D.H.D	☐	☐
b.	Anemia	☐	☐
c.	Anorexia or Bulimia	☐	☐
d.	Anxiety/Depression	☐	☐
e.	Appendicitis	☐	☐
f.	Asthma	☐	☐
g.	Blood/Bleeding Problems	☐	☐
h.	Cancer	☐	☐
i.	Diabetes	☐	☐
j.	Dyslexia	☐	☐
k.	Epilepsy or Seizures	☐	☐
l.	Gallbladder/Gallstones	☐	☐
m.	Head Injury/Concussion	☐	☐
n.	Hearing/Vision Problems	☐	☐
o.	Heart Disease	☐	☐
p.	Hernia	☐	☐
q.	HIV Positive/AIDS	☐	☐
r.	Malaria	☐	☐
s.	Liver Disease/Hepatitis	☐	☐
t.	Menstrual Disorders	☐	☐
u.	Migraine Headache	☐	☐
v.	Pneumonia	☐	☐
w.	Rheumatic Fever	☐	☐
x.	Ulcer	☐	☐
y.	Tumor or Cyst	☐	☐

2. Has the student previously:

		YES	NO
a.	Had any surgical procedures?	☐	☐
b.	Been hospitalized?	☐	☐
c.	Presented any history or current evidence of mental health abnormalities (anxiety, depression, eating disorder, etc.?	☐	☐
d.	Consumed illegal drugs or illegal substances?	☐	☐
e.	Had excessive weight gain or loss?	☐	☐
f.	Suffered chest pain, wheezing, shortness of breath or fainting episodes?	☐	☐

		YES	NO
g.	Had chronic diarrhea, vomiting, abdominal pain or constipation?	☐	☐
h.	Had chronic skin conditions, e.g. severe acne, eczema, or psoriasis?	☐	☐
i.	Had weakness of neurologic or muscular skeletal system?	☐	☐

3. If you answered 'YES' to any responses in questions one and two above, please provide additional information here. Describe the nature, severity, specific diagnosis, frequency, treatment, date and/or duration:

4. Is the student currently?

		YES	NO
a.	Allergic or intolerant to any food(s)?	☐	☐
b.	If yes, please list food, adverse reaction and treatment:		
c.	Allergic to any medication? If yes, please list medication:	☐	☐
d.	Allergic to cats?	☐	☐
	If yes, can the student live with indoor cats?	☐	☐
e.	Allergic to dogs?	☐	☐
	If yes, can the student live with indoor dogs?	☐	☐
f.	Allergic to any environmental or household allergens? If yes, please list:	☐	☐
g.	Experiencing additional allergies not described above? If yes, please list:	☐	☐

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5. Will the student be taking any medication on exchange with him/her?

YES	NO
☐	☐

If yes, list medication name (international and generic names), dose, frequency and reason for use:

6. Physician Examination

Please state if there are any abnormal finding in today's examination:

		YES	NO
a.	Head and neck	☐	☐
b.	Ears, nose and throat	☐	☐
c.	Chest/lungs	☐	☐
d.	Heart (murmur / pressure)	☐	☐
e.	Abdomen (mass)	☐	☐
f.	Hernia	☐	☐
g.	Lymph nodes	☐	☐
h.	Genitalia	☐	☐
i.	Extremities (muscular)	☐	☐
j.	Skeletal System	☐	☐
k.	Neurological	☐	☐
l.	Skin	☐	☐

If you answer 'YES', please provide detailed information on a separate paper which includes the student's full name.

Student's Height: _____ ☐ cm ☐ ft, inches

Student's Weight: _____ ☐ kg ☐ pounds

Blood Pressure: _____ Sys. _____ Dia. _____

Pulse/Rate/minute: _____

7. Confirmation of Diseases:

Indicate if the student had the following:

		YES	NO	Month/Year
a.	Measles (Rubeola)	☐	☐	_____
b.	Mumps	☐	☐	_____
c.	Whooping Cough	☐	☐	_____
d.	Hepatitis	☐	☐	_____
e.	German Measles	☐	☐	_____
f.	Chickenpox	☐	☐	_____

8. Tuberculosis Screening (select one):

☐ Mantoux Test
☐ Chest X-Ray
☐ IInterferon Gamma Release Assay (IGRA)

Date: (Year/Month/Day):_____
Results: ☐ Positive ☐ Negative

Please note that the test result cannot be older than three months (3 Months) when the child enters the US.

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9. Physician's Confirmation and Certification

How long have you known the student? _____

I certify that I hold a valid current license to practice medicine and I have personally examined the student herein named and have accurately reported my findings in this report and/or on a separate report which is attached hereto. I certify that I am not an immediate relative of the patient.

_____
Physician's Name (print clearly)

_____
Physician's Signature

_____
Date:

Stamp:

10. Natural Parent's Confirmation

I certify that I provided the physician noted above with complete details and truthful information about my child's mental and medical health history, and that the information noted in this statement is inclusive of these facts.

I understand that my child cannot gain admission to a high school abroad if they have not received the necessary immunizations. I grant permission for my child to receive any missing immunizations in the U.S. after their arrival on program (at the natural parent's expense).

I understand that my child's insurance while abroad does not cover care/treatment for pre-existing conditions, mental health, and/or for activities deemed by the insurance company as dangerous, etc. An inclusive list is available in iE's online system.

_____
Parent's Signature

_____
Date

Yo certifico que he proporcionado al médico datos e información verdadera
sobre el menor a mi cargo en naturaleza mental y de historial médico,
y toda los datos reflejados en este informe están basada en dicha información

Entiendo que el menor a mi cargo puede no conseguir ser admitido en un colegio
en el extranjero si no tiene las vacunas necesarias.
Doy permiso para que se administren al menor a mi cargo aquellas vacunas que sean necesarias
en EEUU una vez allí corriendo con los gastos.

Entiendo que el seguro proporcionado para su estancia en el extranjero no cubre enfermedades preexistentes, enfermedades mentales ni actividades consideradas peligrosas por el seguro.
Se facilitará información del seguro antes de la salida.

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11. IMMUNIZATIONS: List dates of last booster and dose received. All immunizations are required to study abroad in the USA.

Immunization	Doses Required	Dates Received
Diphtheria	**4**	1)_____ 2)_____ 3)_____ 4)_____ month/day/year month/day/year month/day/year month/day/year
Tetanus	**4**	1)_____ 2)_____ 3)_____ 4)_____ month/day/year month/day/year month/day/year month/day/year
Pertussis (Whopping Cough)	**4**	1)_____ 2)_____ 3)_____ 4)_____ month/day/year month/day/year month/day/year month/day/year
Rubella (German Measles)	**2**	1)_____ 2)_____ month/day/year month/day/year
Rubeola (Measles)	**2**	1)_____ 2)_____ month/day/year month/day/year
Mumps	**2**	1)_____ 2)_____ month/day/year month/day/year
Polio SABIN (TOPV) – 3 required SALK (IVP) – 4 required	**3/4**	1)_____ 2)_____ 3)_____ 4)_____ month/day/year month/day/year month/day/year month/day/year **Check type of Vaccine:** SALK (IVP)_____ SABIN (TOPV)_____ **ATENCIÓN** ***The final dose must be on or after 4th birthday**
Hepatitis B	**3**	1)_____ 2)_____ 3)_____ month/day/year month/day/year month/day/year
Hepatitis A	**3**	1)_____ 2)_____ 3)_____ month/day/year month/day/year month/day/year
Diphtheria/Tetanus/Pertussis Booster (Tdap, DTP or Di Te Per)	**1**	1)_____ month/day/year **ATENCIÓN** *** Tdap booster containing Diphtheria/Tetanus/Pertussis must be given on or after 7th birthday**
Meningococcal (MCV4 = A, C, Y and W-135)	**1**	1)_____ month/day/year
Varicella (Chicken Pox)	**2**	1)_____ 2)_____ month/day/year month/day/year **ATENCIÓN** ***Even if the student had the chicken pox he/she might need the immunization**

Missing Test Results and/or Immunizations (to be completed by the student's physician):

List below any vaccinations missing at the time of your medical examination which will be provided at a later date.

STUDENTS: Please upload a revised immunization form to iE's online system if your immunization records change prior to your exchange program.

Test Results/Immunizations: **Estimated Date:**

_____ _____

_____ _____

_____ _____

_____ _____

Full legal name of student _____

_____ ☐ male ☐ female Date of birth: _____
Full legal name of student

12. DENTAL

For the Dentist

This student is considering to study abroad as an exchange student. Insufficient, inadequate or improper information about the student relative to medications, psychiatric, psychological, or other medical problems could put the life of the student in danger while overseas. Allergy information in particular is critical to school and host family placement and the student's safety and wellbeing. This Dental Examination is part of a general overview of the student's health status and may not be completed by an immediate relative of the student.

Dental Examination

_____
Date of Examination

I certify that I have examined the student's teeth and found them to be:
- ☐ Satisfactory
- ☐ Defects in the process of being corrected
- ☐ Under orthodontic care

Comments:

If the student will need orthodontic care, attach a statement from the orthodontist indicating present status, exact care essential and the date care will be needed.

_____
Dentist's Name (print clearly)

_____
Dentist's Signature

_____
Date:

Stamp:

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Información insuficiente, inadecuada o no exacta sobre sus medicaciones, psiquiatría, su condición psicológica o cualquier otro problema médico puede poner en serio peligro la vida del estudiante durante su estancia en el extranjero.
La información relativa a alergias is de máxima importancia para el colegio y la familia de acogida así como para conformar una estancia segura y apropiada.
Este informe médico dental es parte del informe médico general y ayuda a componer una visión general de la salud del estudiante.
Este informe no puede ser certificado por ningún pariente directo del estudiante.