

MEDICAL INFORMATION

[TO BE COMPLETED, SIGNED AND STAMPED BY THE STUDENT'S PHYSICIAN]

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ COUNTRY: _____

The student must have a physical examination with a licensed physician, who is not a family member, within the 12 months preceding his/her arrival in the USA. The physician should complete this report to provide details of the applicant's medical history, current health and Immunizations. Any changes in health status must be reported prior to arrival in the USA.

01. MEDICAL HISTORY

Has the applicant ever had a history of any of the following?

Yes/No

- ☐ ☐ Allergies to drugs, food, etc.
- ☐ ☐ Appendicitis
- ☐ ☐ Asthma
- ☐ ☐ Cancer
- ☐ ☐ Celiac Disease
- ☐ ☐ Chicken Pox
- ☐ ☐ Cough (Persistent)
- ☐ ☐ Diabetes Mellitus
- ☐ ☐ Enuresis

Yes/No

- ☐ ☐ Goiter (Thyroid)
- ☐ ☐ Headache (Persistent)
- ☐ ☐ Hepatitis
- ☐ ☐ Hernia
- ☐ ☐ Malaria
- ☐ ☐ Measles
- ☐ ☐ Mumps
- ☐ ☐ Menstrual Disorder
- ☐ ☐ Mental Health Disorder

Yes/No

- ☐ ☐ Parasites
- ☐ ☐ Pneumonia
- ☐ ☐ Poliomyelitis
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Scarlet Fever
- ☐ ☐ Seizure Disorder
- ☐ ☐ Sleep Disorder
- ☐ ☐ Tuberculosis
- ☐ ☐ Vertigo, Dizziness

Any disease, impairment or abnormality of:

Yes/No

- ☐ ☐ Blood, Endocrine System
- ☐ ☐ Bones, Joints
- ☐ ☐ Brain, Nervous System
- ☐ ☐ Digestive System
- ☐ ☐ Ears, Hearing

Yes/No

- ☐ ☐ Eyes, Vision
- ☐ ☐ Genito-Urinary System
- ☐ ☐ Heart, Blood Vessels
- ☐ ☐ Locomotor System
- ☐ ☐ Respiratory System

Yes/No

- ☐ ☐ Skin (acne, etc.)
- ☐ ☐ Teeth and Gums
- ☐ ☐ Tonsils, Throat, Nose
- ☐ ☐ Varicose Vains
- ☐ ☐ Other _____

Does the applicant have or ever had any of the following?

Yes/No

- ☐ ☐ Restriction of a physical activity during the past five years

Yes/No

- ☐ ☐ Treatment or counseling for any mental health condition, personality or character disorder

Yes/No

- ☐ ☐ Learning or speech disorder.

If "yes" was checked for any of the above, please provide more details:

PHYSICIAN'S STATEMENT OF HEALTH

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ COUNTRY: _____

Height: _____ Weight: _____ Blood Pressure: _____ Blood Type: _____

Does student wear contact lenses? ☐ Yes ☐ No Does student wear prescription glasses? ☐ Yes ☐ No

Applicant's uncorrected vision: R 20 / ____ L 20 / ____ With correction: R 20 / ____ L 20 / ____

Hearing: _____

Has the applicant ever consulted with or been treated by a specialist for any of the following?

Yes/No

- ☐ ☐ ADD/ADHD
- ☐ ☐ Alcoholism
- ☐ ☐ Anxiety
- ☐ ☐ Attempt Suicide
- ☐ ☐ Autism Spectrum

Yes/No

- ☐ ☐ Cutting or other forms
of self-harm behavior
- ☐ ☐ Depression
- ☐ ☐ Eating Disorders
- ☐ ☐ Gender Identity Questions

Yes/No

- ☐ ☐ Panic Attacks
- ☐ ☐ Mood Swings
- ☐ ☐ Substance Abuse
- ☐ ☐ Other _____

If yes, to any of the above please explain:

Please provide details of any treatment and medication used.

Is the applicant currently taking any medication or injections? ☐ Yes ☐ No If yes, please explain:

Will the applicant bring any prescription medication to the USA? ☐ Yes ☐ No If yes, please explain:

Please include the names, purpose, dosage and frequency of use of these medications.

Has the applicant ever been hospitalized? ☐ Yes ☐ No If yes, please explain:

Recommendation for physical activity: ☐ Unlimited ☐ Limited

Your opinion on the patient's state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

PHYSICIAN'S SEAL

Physician's Signature: _____

Printed Name: _____

Country: _____ Date: _____

