

STUDENT:
GENDER - DOB:
COUNTRY:

MEDICAL PROFILE OF A SCHOOL AGE STUDENT

PARENT / GUARDIAN:

Complete pages 1 and/or 2 before presenting them to the physician for the physical exam, if possible. If not, have the physician fill it out. Have a physician verify pages 1 and 2 and fill out Page 3; use Page 4 to **provide specifics (date, severity, etc.)** for any questions marked YES on Page 1 (Medical History).

Student's Parent / Guardian _____

MEDICINES

Please list all prescription and over the counter medicines and supplements (herbal/nutritional) the student is currently taking:

ALLERGIES

Does the student have any significant allergies: NO YES (if yes, select specific allergies and reaction)

Medicines: _____

Reaction: _____

Pollens/Seasonal: _____

Reaction: _____

Food: _____

Reaction: _____

Insects/Animals: _____

Reaction: _____

Complete the following section with an "X" in the YES column, if applicable. Leave blank if an answer to a question is NO.

GENERAL HEALTH: Has the student...	YES	BONE/JOINT: Has the student...	YES
1. Any ongoing medical conditions? If so, please identify: Asthma Anemia Diabetes Infection		20. Had a broken or fractured bone, stress fracture or dislocated joint?	
Other _____		21. Had an injury to a muscle, ligament, or tendon?	
2. Ever stayed more than one night in the hospital?		22. Needed an X-Ray, MRI, CT scan, injection, or physical therapy following an injury?	
3. Ever had a surgery?		23. Had joints that become painful, swollen, feel warm, or look red?	
4. Ever had a seizure?		SKIN: Has the student...	YES
5. Had a history of being born without or missing a kidney, an eye, a testicle (males), spleen, or any other organ?		24. Had any rashes, pressure sores, or other skin problems?	
6. Ever become ill while exercising in the heat?		25. Ever had herpes or MRSA skin infection?	
7. Had frequent muscle cramps when exercising?		GENITOURINARY: Has the student...	YES
HEAD/NECK/SPINE: Has the student...	YES	26. Had groin pain or painful bulge or hernia in the groin area?	
8. Had headaches with exercise?		27. Had a history of urinary tract infections or bedwetting?	
9. Ever had a head injury or concussion?		DENTAL:	
10. Noticed or been told he/she has a curved spine or scoliosis?		28. Has the student had any pain or problems with his/her gums or teeth?	
11. Had any problem with eyes (vision) or had an eye injury?		29. Last dental visit: < than 1 year 1-2 years > 2 years	
12. Been prescribed glasses or contact lenses?		SOCIAL/LEARNING/PSYCHOLOGICAL: Has the student...	YES
13. Had any hearing loss or problems with hearing?		30. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?	
HEART/LUNGS: Has the student...	YES	31. Been bullied or experienced bullying behavior?	
14. Ever used an inhaler or taken asthma medicine?		32. Experienced major grief, trauma, or other significant life events?	
15. Ever had a doctor say he/she has a heart problem? If so, please identify: Murmur or Infection High Blood Pressure High Cholesterol Kawasaki disease		33. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?	
Other _____		34. Been worried, sad, upset, or angry much of the time?	
16. Been told by a doctor to have a heart test (ECG/EKG, etc.)		35. Shown a general loss of energy, motivation, interest or enthusiasm?	
17. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		36. Had concerns about weight: been trying to gain or lose weight or received a recommendation to gain or lose weight?	
19. Felt his/her heart race or skip beats during exercise?		37. Used (or currently uses) tobacco, alcohol, or drugs?	
18. Had discomfort, pain, tightness or chest pressure during exercise?		38. Ever had a doctor evaluate him/her for a social, learning and/or psychological concern?	
		QUESTION or CONCERNS:	YES
		39. Are there any other questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (if yes, write them on Page 4)	

I hereby certify that to the best of my knowledge all of the information is true and complete.

Signature of Parent / Guardian _____ Date _____

Signature of Medical Provider/Physician _____ Date _____

STUDENT: **Carlos Masa Tellez**
 GENDER - DOB: **Male - 06/01/2010**
 COUNTRY: **Spain**

GENERAL INSTRUCTIONS FOR IMMUNIZATIONS:

Could be preliminarily filled out by the Parent/Guardian, but must be verified and signed by a physician.

Please write legibly the month/day/year of every dose administered. Non-legible immunization history will be denied.

If a specific vaccine is medically contraindicated, please use additional space on Page 4 to explain the medical reason for contraindication.

Record Complete dates (Month / Day / Year) of vaccine doses given.

IMPORTANT: Vaccines marked with (*) are required. Follow the specific dosage/instructions in gray to avoid school enrollment issues. Students should check their immunizations once their host family's/schools location is confirmed. Missing required state (or province) immunizations at arrival will need to receive them before entering school. Vaccines administered while in our program will come at a cost to the student, and will not be covered by insurance.

Program will come at a cost to the student, and will not be covered by insurance.						
Vaccine / Dose	1	2	3	4	5	6
* Diphtheria, Tetanus, Pertussis (DTP, DTaP, Td)	1	2	3	4	5	6
* Tetanus, Diphtheria, Pertussis booster after 7 years of age (Tdap)	1	DTaP 5 doses or 4 doses if the 4th dose was received at 4 years or older or 3 doses if 7 years or older and the series was started at 1 year or older Tdap: There is no minimum interval from the last Td dose as long as the dose was received at 7 years or older				
* Poliomyelitis (IPV, OPV)	1	2	3	4	3 doses of Polio are acceptable for all grade levels if the 3rd dose was given on or after the 4th birthday and at least 6 months after the previous dose	
* Measles, Mumps, Rubella (MMR)	1	2	The first dose of MMR vaccine must have been received on or after the first birthday. The second dose must have been received at least 28 days (4 weeks) after the first dose to be considered valid. Measles, Mumps: 2 doses are required Rubella: At least one dose is required			
* Varicella (Chickenpox)	1	2	Serological Confirmation of Immunity: Date of Blood Test (attach test results) / Date of Disease			
* Hepatitis B (HBV)	1	2	3	3 doses or 2 doses of adult hepatitis B vaccine (Recombivax) for children who received the doses at least 4 months apart between the ages of 11 through 15 years The minimum age for the 3rd dose of Hepatitis B is 24 weeks of age		
COVID-19	1	2	Serological Confirmation of Immunity: Date of Blood Test (attach test results) / Date of Disease			
Hepatitis A (Required by half of the placement locations)	1	2	Serological Confirmation of Immunity: Date of Blood Test (attach test results) / Date of Disease			
Meningococcal (MCV4) (Required by majority of the placement locations)	1	2	Meningococcal conjugate ACWY vaccine. (minimum age: 6 weeks) 2 doses or 1 dose if the dose was received at 16 years or older			
Human Papillomavirus	1	2	3	Females only		
Other	1	2	3	4	5	6
Other	1	2	3	4	5	6
Other	1	2	3	4	5	6

Remarks/Contraindications

I hereby certify that this child is adequately or age-appropriately immunized and I verify the above immunization history.

If dates are added to the above immunization history after it was originally signed, put initials by date(s) and sign again here.

Print Name of Medical Provider/Physician _____ Date _____

Signature of Medical Provider/Physician _____ Date _____

STUDENT: Carlos Masa Tellez
GENDER - DOB: Male - 06/01/2010
COUNTRY: Spain

MEDICAL PROVIDER/PHYSICIAN:

Please review and sign the Student's History (Page 1)
Use Page 4 to provide any comments and or clarifications of questions marked YES on Medical History (Page 1) and/or Physical Exam

EXAM	CHECK ONE			ABNORMAL FINDING/ RECOMMENDATIONS / DEFERRALS
	NORMAL	ABNORMAL	DEFER	
Height (in / cm):				https://www.cdc.gov/healthyweight/bmi/calculator.html
Weight (lb / kg):				
Body mass index (BMI):				
BMI-for-Age Percentile: %				
Pulse:				
Blood Pressure: /				
Hair/Scalp				
Eyes/Vision Corrected				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis, etc.)				
Other				

Tuberculosis (TB) Screening (please write the date in month/day/year format legibly):

Only 1 test is required	TB Blood Test Date	Results	
	Mantoux (TST) Test Date	Date Read	Results
Required if a test is positive	Chest X-Ray Date	Results	

! Psychological conditions, medical conditions or chronic diseases which require medication, restriction/limitation of physical, inter-personal/social and/or academic activities !
(circle the appropriate option below and provide comments on Page 4, if applicable)

- Full unlimited participation/ability
in ALL sports/physical, social and academic activities
- Limited participation/ability
in physical, social or academic activities
(specify which ones on Page 4)
- No participation
in sports activities
(specify why on Page 4)
- Other conditions / chronic diseases exist
(specify all details on Page 4)

Print Name of Medical Provider/Physician _____

Signature of Medical Provider/Physician _____ Date _____

Page 4 of 4

ADDITIONAL MEDICAL COMMENTS

Please complete this page in English (if necessary, translate and include original language findings as an additional page)
Please add comments if "Yes" was checked on Medical History or if further clarification regarding immunizations or physical exam is needed.

[illegible]

Signature of Medical Provider/Physician _____ Date _____