Culver City Sister City Committee

Student Exchange Program - Certificate of Health

Your Acceptance is contingent on returning this document to CCSCC, fully completed in English by your physician.
Please type or print only.

_____ Male ____ Female ____ Age ____
(Print: Last Name) (First Name)

_____ _____
(Address, City, State, Zip) (Home Phone Number)

Part I To be completed and SIGNED BY APPLICANT'S PARENT BEFORE VISITING THE PHYSICIAN

A. Have you, to the best of your knowledge, ever had any of the following: (Each item must be "yes" or "no")

Hernia ____
Sinusitis ____
Hay Fever ____
Asthma ____
Goiter ____
Cancer ____
Fever (type) ____ (_____)
Stomach Disorder ____
Bulimia ____
Anorexia ____
HIV Virus (AIDS) ____
Eye Disease ____
Ear Disease ____
Heart Disease ____

Intestinal Disorder ____
Cholera ____
Small Pox ____
Diabetes (1) or (2) ____
Typhoid ____
Paralysis ____
Pneumonia ____
Appendicitis ____
Tuberculosis ____
Rheumatic Fever ____
Frequent Colds ____
Tonsillitis ____
Gall Bladder ____
Rectal Disease ____

Arthritis ____
Sciatica ____
Rheumatism ____
Disease of Skin ____
Venereal Disease ____
Mental Disorder ____
Nervous Sys. Disease ____
Allergies ____
Disease/Disorder Back ____
Disease/Disorder Spine ____
Disease/Disorder Kidney ____
Genitourinary Disorder ____
Prostate Disease ____
Abnormal Blood Pres. ____

If you have answered "yes" to any of the above, give: (1) specific name of disorder; (2) duration – specify dates; (3) final results. (If none, write "none")

_____
_____

B. During the past five years, when and for what injury, illness or medical disorder (including any of the above or Others) have you been under observation; had medical or surgical advice or treatment; been hospitalized? Give: (1) Specific name of disorder; (2) duration – specify dates; (3) final results. (If none, write "none")

_____
_____

C. To the best of knowledge and belief, are you now in good physical health free from impairment or deformity? Yes _____ No _____ (If no, give specific name of disorder, treatment and present condition)

_____
_____

D. Are you currently taking any injection(s)/medication(s)? Yes___ No ___ If yes, list name(s) and reason(s) for use. _____
_____

I declare that the above statements are <u>true</u>. I understand that reporting false information is justification for rejection of application and/or my being asked to return home.

Signature of applicant/parent: _____ _____

Part II **Medical Information**

Please be as thorough as possible. This will only be used to help your child be safe and happy during the trip. Please print or type.

Student: _____ Age ____ Birthdate _____

Health Insurance Provider _____
Group Number _____ Subscriber No. _____
Does your provider have coverage outside of the U.S.A.? Any special requirements or things you/we need to obtain for them from the doctor or hospital? _____

_____

Does your child take any regular prescription medications? _____

If so, for what? _____

Does your child have any health problems the chaperone and or host family needs to be aware of? _____

_____

If a daughter, has she started menstruation? _____ If not, is she prepared? _____

Date of last tetanus shot: _____ Flu immunization? _____

Does your child have any allergies or sensitivities that the chaperone or host family needs to be aware of?

If so, please be specific as to the allergy/sensitivity and if they take medication_____

_____

Students should bring over the counter medications for headache, upset stomach, etc. Please check the Internet for particular medicines or medical supplies forbidden to transport into the country without a physician's letter. In the event that your child is on a daytrip and does not have his/her meds., do the chaperones have permission to give your child such medications as Tylenol, Pepto Bismol, etc.? Please indicate your wish/preferences below: _____

_____

Please share any other medical history or information about your child: _____

_____

_____ _____

Parent/Guardian's signature / Date Parent/Guardian's signature / Date

Culver City Sister City Committee Inc. Exchange Program - Certificate of Health

Part III – To be completed, signed and returned by your physician

Please provide an addressed and stamped envelope to the address on the bottom of the form

The student listed below is being considered as a delegate for an international exchange visit and is required to provide the information listed below.

Student's Name: _____
Student's Address & Phone Number: _____
_____

A. Insert height and weight, for the rest, enter "N" if normal. Enter "AB" if abnormal and describe in detail under remarks.

Height _____ Head _____ Hernia _____

Weight _____ Nose _____ Reflexes _____

Eyes _____ Rectum _____ Heart _____

Ears _____ Pharynx _____ Abdomen _____

Neck _____ Lungs/Clear? _____

Comments: _____

_____

B. Has the applicant ever suffered from any nervous or mental disorders? _____

_____

C. Does the applicant show any sign of communicable diseases, over fatigue or physical defects? Yes____ No ____

D. In my opinion, the applicant's health and physical condition are: Good _____ Fair _____ Poor _____

Remarks: Describe any abnormalities noted in Part II – A, B, C or D and add any other comments: _____
_____
_____
_____

Name & title of Physician (Print) _____ Date _____
License No. _____
Address _____
Signature _____

Please mail completed confidential document to:

Culver City Sister City Committee, Inc.
Student Exchange Program/Chairperson
P. O. Box 1072
Culver City, California 90230