CAMP EXCHANGE USA

MEDICAL FORM

Participant's Name (please print)_____ **Date of Birth:**_____

To the Physician

You are being asked to provide information on the physical and mental health of the above-named participant to live and work with youth twenty-four hours a day for a period of up to ten weeks on the Camp Exchange USA program. This is a highly strenuous program and the environment can create emotional and physical stress for those not able to meet the demands of the activities and schedule in this new and different environment. In some cases, mild disorders can become serious under the stress of life in alien surroundings with little privacy or amenities in a rugged environment, where they are often asked to put the needs of youth before their own.

It is essential that your reply be based on a current and thorough physical examination and knowledge of the applicant's medical history. Any additional comments relevant to the patient's physical or psychological condition should be provided on a separate sheet signed and dated by you, the physician.

To be completed by the physician:

1. How long have you known the applicant?

2. What is the date of the applicant's most current examination?

3. Are you:
   - ☐ Applicant's family physician
   - ☐ College physician
   - ☐ Other

4. What is the applicant's general state of health?
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

5. Please indicate the applicant's vital signs (at rest):
   a. Pulse Rate
   b. Skin
   c. Respiration
   d. Temperature
   e. Blood Pressure

If the answer to **any** of the following questions is yes, please give details on a separate sheet. In each case please indicate whether the condition is likely to affect the participant's full participation in the program.

		YES	NO
6.	Is the applicant seriously underweight or overweight?	☐	☐
7.	Is the applicant currently taking any medications? If so, what medications?	☐	☐
8.	Is the applicant allergic to any form of medication?	☐	☐
9.	Has the applicant received the following immunizations? If yes, please provide the date of last immunization.	☐	☐
	DATE		
a.	Diphtheria, Pertussis, Tetanus (DPT)	☐	☐
b.	Mumps, Measles, Rubella (MMR).	☐	☐
c.	Polio (Oral or Injectable)	☐	☐
d.	Hepatitis A	☐	☐
e.	Hepatitis B	☐	☐
f.	Please list all other:	☐	☐
10.	Has the applicant ever suffered from asthma or any other respiratory ailment?	☐	☐
11.	Is the applicant currently under treatment or observation for any physical or emotional condition?	☐	☐
12.	Does the applicant have any history of seizures?	☐	☐
13.	Does the applicant have any speech, hearing, or eyesight impairment that might affect participation in the program?	☐	☐
14.	Has the applicant any physical disability that might cause hardship through change of diet, or strenuous activity?	☐	☐
15.	In your judgment will the applicant require assistance from an aide or other second party because of an existing condition at any time on the program?	☐	☐
16.	Is there any congenital malformation now existing that may require additional treatment? If yes, what is this congenital condition and what treatment is to be pursued? (Please note that CIEE's insurance coverage does not include treatment of preexisting conditions.)	☐	☐
17.	Does this person have a history of emotional disturbance? Has the applicant displayed any behavior disorders, symptoms such as mood swings, depression, severe sleep disorders, or unusual degree of anxiety, fear, or guilt? Please explain:	☐	☐
18.	To your knowledge, are there any predisposing medical, surgical, or emotional factors that may under stress or duress during the program present a need for immediate therapy while abroad? Please explain:	☐	☐

Any additional comments relevant to the patient's physical or psychological condition should be provided on a separate sheet signed and dated by you, the physician.

Physician's Name _____ Physician's Signature _____ Date _____

Physician's Address _____ Physician's Phone Number _____