**IF THIS INFORMATION IS PROVIDED ELSEWHERE IN YOUR APPLICATION PACKET, PLEASE ATTACH.**

## Peninsula School District
## Exchange Student Medical and Dental Examination Report

Name of Applicant: ______________________________ ❍Male ❍Female

Address: ______________________________

Telephone Number: ______________________________

**Explanation:** A year in the United States for young person most often is exciting and broadening, but it can also be emotionally and physically distressing at times. Because of our concern that the chosen youth be able to succeed, we ask for your thoughtfulness in completing this examination, as authorized by the parents and applicant.

**Part A (To be completed by the dental examiner)**
This needs to be signed by the family dentist indicating the state of dentition, and noting any dental problem which may occur during absence in the United States and which may require attention while the applicant is abroad.

Does the applicant have any dental problems at present? ❍Yes ❍No
Is dental work required at this time? ❍Yes ❍No
Do you foresee any dental problems during applicants planned stay abroad? ❍Yes ❍No
If any answers are "Yes", please explain:

Signature ______________________________ Date: ______________________________

Printed Name: ______________________________

Address: ______________________________

Telephone (including area code): ______________________________

**Part B (Declaration by applicant)**

Have you or has any member of your family ever had any serious illness or surgical operations? ❍Yes ❍No
If yes please explain:

Have you or has any member of your family ever suffered from been suspected of suffering from tuberculosis? ❍Yes ❍No
If yes, please explain:

Have you or has any member of your family ever suffered from a mental disease, fits of epilepsy, or been treated in an institution for any kind of these diseases? ❍Yes ❍No
If yes please explain:

What medical attention have you required during the last twelve months?

We hereby authorize the release of medical information acquired in the course of examination by the undersigned physician. (To be signed in the presence of a medical examiner).

______________________________ ______________________________
(Signature of parent/guardian) (Signature of applicant)

## EXAMINATION RESULTS

**Part C (To be completed by the medical examiner who should state if "Normal.")**
Any disability should be noted and commented upon under "Remarks" showing whether it is of a temporary or permanent nature and if it is major or minor degree.

| | |
|---|---|
| Heart: ___ | Genito Urinary Organs: ___ |
| Blood Type: ___ | Is albumen of sugar present in Urine ❍Yes ❍No |
| Lungs: ___ | Height: ___ |
| Nervous System: ___ | Weight: ___ |
| Mental Condition: ___ | Blood Pressure: ___ |
| Digestive Organs: ___ | Hearing: ___ |
| Skeleton (bones and joints): ___ | Sight Without Glasses: L ___ R ___ |
| Skin: ___ | Sight With Glasses: L ___ R ___ |

## HEALTH HISTORY

I certify that the applicant has had or was immunized against the marked diseases on the date indicated:

☐Chickenpox
☐Mumps
☐Tetanus
☐Measles (Rubeola)
☐Polio
☐Whooping Cough
☐German Measles (Rubella)
☐Diptheria
☐TB test

Check any of the following which are special problems and explain:

**Allergies:**
☐Hay Fever
☐Asthma
☐Drugs
☐Insect stings
☐Poison ivy, oak, etc.
☐Food
☐Other ___

**Chronic/Recurring Illness:**
☐Ear infections
☐Heart disease
☐Convulsions
☐Diabetes
☐Behavior
☐Nephritis
☐Epilepsy
☐Other ___

**General:**
☐ Fainting
☐Sleep disturbances
☐Bed wetting
☐Menstruation
☐Constipation
☐Other ___

Suggestions from parents:

Medical examiner's remarks:

❍ I CERTIFY that I have this day examined the above named, that the results are set forth, and in my opinion, subject to any special observations under "Remarks," the above named is in good health and of sound constitution and not suffering form any mental or physical defect which would preclude his/her participation in this program.

❍ The above named suffers a mental of physical defect as noted and is NOT in good health.

Signed: ___ Date: ___

Printed Doctor's Name: ___ Telephone: ___

Address: ___