Educational Services Center
International Education Programs Office

527 S. Franklin St. • Janesville, WI 53548
(608) 743-5055 • FAX (608) 743-7491

STATEMENT OF APPLICANT'S HEALTH

Applicant's Name: ____

Address: ____

Country: ____

This statement must be completed by attending physician who is not related to the student.

Several categories of questions are listed on the next few pages. Please check the line(s) under yes for any of the items that apply.

Has the applicant ever had any of the following? **If yes, is checked, please explain in English.**

ALLERGIES

Yes **List / Explain (give date where relevant)**

_____ Drugs ____

_____ Food ____

_____ Smoke ____

_____ Bees, Insects, Pet ____

_____Other ____

Has the applicant ever had any medical issues of the following? **If yes, please explain in English.**

BODY SYSTEMS

Yes **List / Explain (give date where relevant)**

_____ Asthma, Respiratory ____

_____ Cardiac, Murmurs ____

_____ Abdominal/Digestive ____

_____ Musculature & Skeletal (fractures) ____

_____ Genito-Urinary System ____

_____ Brain, Nervous & Sensory Organs ____

_____ Blood, Endocrine System ____

_____ Smoke ____

_____ Integumentry (skin) ____

_____ Joint, Locomotor System ____

STATEMENT OF APPLICANT'S HEALTH (continued)

Has the applicant ever had any of the following? **If yes, please explain in English.**

DISORDERS

Yes **List / Explain (give date where relevant)**

______ Seizures ____

______ Eating ____

______ Attention Deficit ____

______ Depression ____

______Learning or Speech Deficit ____

Has the applicant ever had any of the following? **If yes, please explain in English.**

SURGERIES

Yes **List / Explain (give date where relevant)**

______ Appendectomy ____

______ Tonsillectomy ____

______ Adenoidectomy ____

______ Other ____

Has the applicant ever had any of the following? **If yes, please explain in English.**

BODY SYSTEMS

Yes **List / Explain (give date where relevant)**

______ Scarlet Fever ____

______ Measles (Rubella) ____

______ Mumps ____

______ Chicken Pox ____

______ Rheumatic Fever ____

______ TBC - Tuberculosis ____

______ Malaria ____

______ Rubella ____

______ Hepatitis A ____

______ Hepatitis B ____

______ Hepatitis C ____

______ Varicella ____

______ Other ____

STATEMENT OF APPLICANT'S HEALTH (continued)

Has the applicant ever had any of the following? **If yes, please explain in English.**

OTHER HEALTH ISSUES

Yes **List / Explain (give date where relevant)**

_____ Cough (persistent, recurring) ____

_____ Ear Infections, history of ____

_____ Diabetes Mellitus ____

_____ Hernia ____

_____ Eyes or Vision ____

_____ Enuresis ____

_____ Varicose Veins ____

_____ Goiter (Struma)____

_____ Headache (persistent, recurring) ____

_____ Migraines ____

_____ Sleepwalking ____

_____ Parasites (intestinal, other) ____

_____ Vertigo, Dizziness ____

_____ Tonsils, Sore Throat ____

_____ Nose Bleeds (persistent, recurring) ____

_____ Urinary Tract Infections ____

_____ Thyroid Conditions ____

_____ Other ____

STATEMENT OF APPLICANT'S HEALTH (continued)

Provide figures for the following about the applicant:

Blood Type (if known): _______ Height: _________ Weight: ________
Blood Pressure: _____________
Vision without Glasses: OD ____________ OS ____________
Vision with Glasses: OD ____________ OS ____________
Date of last eye exam ____/_____/_____ Wears Glasses __ Wears contacts __ Wears Both __
Does applicant have any scars or identifying marks? Yes ___ No ___
If yes, please describe: ____
____
____

Are there any restrictions on the applicant's participation in physical education, field trips, cultural outings, extra-curricular, and/or sports activities? Yes ___ No ___ If yes, please detail any disease, impairment, or abnormality not fully explained on this Statement of Applicant's Health which would explain why the applicant cannot participate in the activities listed above:

____
____

VACCINE INFORMATION

Has applicant ever received BCG vaccine? Yes ___ No ___
If yes, please provide date and sign confirmation below that applicant is free of TB: ____/____/_____
My patient, ____ is free of TB.
Doctor's signature ____
If no, applicant must have had a TB test within the past year: Date of test: ____/_____/_____
Tuberculin Skin test: _____+ _____ - If applicant has a positive skin test, then a report of negative chest x-ray and copy is required:
Type of test: _____ PPD _____Mantoux chest x-ray + date of x-ray ____/_____/_____
Has applicant ever received Hepatitis A vaccine? Yes ___ No ___
If yes, please give dates of vaccinations: 1st dose: ____/_____/_____ 2nd dose: ____/_____/_____
3rd dose: ____/_____/_____

We strongly encourage the following additional vaccinations. Please refer to the State of Wisconsin Immunization Information for other required vaccines and fill out the Student Immunization Record.

Has applicant received the Influenza Vaccine? Yes ___No ___Date of Vaccine: ____/_____/_____
Has applicant received the Meningococcal Vaccine? Yes ___No ___Date of Vaccine: ____/_____/_____

STATEMENT OF APPLICANT'S HEALTH (continued)

COMPLETE IMMUNIZATION RECORD FORM

Your opinion of the state of the candidate's health:

___Excellent ___Good ___Fair ___Poor

I, the undersigned, have reviewed the medical history of the applicant and given a thorough physical examination and certify that all important medical information has been noted on this form and that nothing relevant has been committed.

The applicant is physically fit enough to participate in a school sport activity if the student chooses to do so.

Physician's Signature: ____

Name (print) ____

Address: ____

City: ____ Province/State: ___________________________

Country: ______________________________________

Date: ____

Please affix seal, stamp, or provide medical license number for verification purposes

____

Thank you.