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: _____