



To be completed and signed by the candidate's physician. The physician should not be related to the candidate. Each question must be answered with a detailed explanation included or attached in a separate report for "YES" responses to questions 3-9, 11-13. AFS reserves the right to ask for further information and determine if the candidate meets the program medical qualifications. The candidate and parent/guardian must also sign.

(Ms.) (Mr.) Candidate Name (First/Middle/Last) Home Country Birthdate

1 Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ Blood Type \_\_\_\_\_

2 Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration?  Yes  No If yes, explain \_\_\_\_\_

**3 CHECK YES OR NO. HAS THE CANDIDATE HAD THE DISEASES / CONDITIONS LISTED BELOW:**

|                  | YES                      | NO                       | IF KNOWN:                 |                                      | YES                      | NO                       |
|------------------|--------------------------|--------------------------|---------------------------|--------------------------------------|--------------------------|--------------------------|
| a) Measles       | <input type="checkbox"/> | <input type="checkbox"/> | Titer: _____ Date: _____  | h) Rheumatic Fever                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Mumps         | <input type="checkbox"/> | <input type="checkbox"/> | Titer: _____ Date: _____  | i) Cough (persistent, recurring)     | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Rubella       | <input type="checkbox"/> | <input type="checkbox"/> | Titer: _____ Date: _____  | j) Headaches (persistent, recurring) | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Chicken Pox   | <input type="checkbox"/> | <input type="checkbox"/> | If yes, month/year: _____ | k) Sleepwalking                      | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Poliomyelitis | <input type="checkbox"/> | <input type="checkbox"/> |                           | l) Enuresis                          | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Hepatitis     | <input type="checkbox"/> | <input type="checkbox"/> |                           | m) Appendicitis                      | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Tuberculosis  | <input type="checkbox"/> | <input type="checkbox"/> |                           | n) Parasites (internal)              | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, give detailed information and dates (use extra pages if necessary): \_\_\_\_\_

4 ACNE  Yes  No If yes, identify area, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

5 ALLERGIES  Yes  No If yes, identify type, any medication taken, name dosage & frequency: \_\_\_\_\_

6 ASTHMA  Yes  No If yes, identify type, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

7 DIABETES  Yes  No If yes, identify type, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

8 SEIZURE DISORDER  Yes  No If yes, identify type, severity, any medication taken, name, dosage & frequency: \_\_\_\_\_

**9 HAS THE CANDIDATE EVER HAD ANY DISEASE, IMPAIRMENT OR ABNORMALITY OF:**

|                                       | YES                      | NO                       |                             | YES                      | NO                       |
|---------------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| a) Abdominal organs, digestive system | <input type="checkbox"/> | <input type="checkbox"/> | e) Heart blood vessels      | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Lungs, respiratory system          | <input type="checkbox"/> | <input type="checkbox"/> | f) Tonsils nose or throat   | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Bones, joints, locomotor system    | <input type="checkbox"/> | <input type="checkbox"/> | g) Blood, endocrine system  | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Genito-urinary system              | <input type="checkbox"/> | <input type="checkbox"/> | h) Eyes/vision, ear/hearing | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, please explain (use extra pages, if necessary) \_\_\_\_\_

**10 HAS THE CANDIDATE BEEN HOSPITALIZED?**

Yes  No If yes, give dates, diagnosis and outcome for each incident. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# 3b Health Certificate

FOR OFFICE USE

AFS ID#

Candidate Name (First/Middle/Last)

Home Country

11 Is the candidate currently taking medication or injections (other than those mentioned previously)?  Yes  No  
If yes, identify the medication, reason for usage, dosage and frequency: \_\_\_\_\_

12 Has the candidate EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder?  Yes  No

13 Is there a history of, or present evidence of, an emotional, nervous or eating disorder?  Yes  No

If yes to either (12 or 13), a FULL report by the specialist and a statement by the candidate about the illness or specific problem must be attached in a sealed envelope. Note: Placement in a foreign host family, school and community requires adjustment which often involves emotional stress. It will not be a time for relaxation or temporary relief from any current therapy. If the candidate is experiencing current emotional, physical, personal or family difficulties, these difficulties can be severely exacerbated by the adjustment demands of the AFS program. Therefore, you are requested to evaluate carefully the candidate's current or previous condition and treatment along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment.

14 Are there any health limitations or restrictions on the candidate's activities and / or sports participation or any medical information which should be considered for a home/school placement?  Yes  No If yes, please describe: \_\_\_\_\_

15 Does the candidate wear glasses or contact lenses?  Yes  No

16 What was the date of the candidate's last dental check up? \_\_\_\_\_

Does the candidate wear dental braces?  Yes  No

If yes, will orthodontic care be needed while on the program?  Yes  No Frequency? \_\_\_\_\_

**17 CANDIDATE HAS HAD THE FOLLOWING IMMUNIZATIONS, PLEASE SPECIFY EXACT DAY, MONTH AND YEAR:**

|               | YES                      | DAY/MO/YR | DAY/MO/YR | DAY/MO/YR | DAY/MO/YR | DAY/MO/YR |
|---------------|--------------------------|-----------|-----------|-----------|-----------|-----------|
| Measles       | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Mumps         | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Rubella       | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Diphtheria    | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Pertussis     | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Tetanus       | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Poliomyelitis | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| BCG           | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Hepatitis B   | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |
| Other         | <input type="checkbox"/> | _____     | _____     | _____     | _____     | _____     |

TB Test Which type (circle one) Mantoux or Tine Date: \_\_\_\_\_ Result (+/-)

If positive, was chest x-ray done?  Yes  No Date \_\_\_\_\_ Result (+/-)

I, the undersigned, certify that a thorough physical examination of the candidate has been given and all important recent medical information has been included on Form 3A and 3B, that nothing relevant has been omitted, and that the candidate is able to travel. I understand that the omission of any information could be harmful to the candidate's health care and could result in early termination from the AFS program.

Physician Name and Degree

Signature

Address

Date

Your signature below attests that you understand and accept the AFS Medical Policies as stated on the Participation Agreement, that the information on Form 3A and 3B is correct and complete and that inaccurate or incomplete information could be harmful to the candidate's health care and could result in early termination from the AFS program.

Candidate Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_