3A
Health Certificate

To be completed and by the candidate's physician. **The physician should not be related to the candidate.** Each question must be answered with a detailed explanation included of attached in a separate report for "Yes" responses to questions 2-9 and 12-14 AFS reserves the right to ask for further information and to determine it the candidate meets the program medical qualifications. The candidate must also sign

(Mr.) (Ms.)____

Candidate's name country Date of birth

1. Height____________ Weight____________ B/P____________ Pulse_________ Resp________

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	☐	☐	Titer _____Date _____	h) Rheumatic Fever	☐	☐
b) Mumps	☐	☐	Titer _____Date _____	i) Cough (persistent, recurring)	☐	☐
c) Rubella	☐	☐	Titer _____Date _____	j) Headaches (persistent, recurring)	☐	☐
d) Chicken Pox	☐	☐		k) Sleepwalking	☐	☐
e) Poliomyelitis	☐	☐		l) Enuresis	☐	☐
f) Hepatitis	☐	☐		m) Appendicitis	☐	☐
g) Tuberculosis	☐	☐		n) Parasites (intestinal)	☐	☐

**If yes, give detailed information and dates (use extra pages if necessary)____

4. ACNE ☐ Yes ☐ No If yes, identity area, severity type, any medication takes, name dosage and frequency

5. ALLERGIES ☐ Yes ☐ No If yes, identity type, any medication taken, name, dosage, and frequency

6. ASTHMA ☐ Yes ☐ No If yes, identity type and severity____
Identity any medication taken, name, dosage, and frequency____

7. DIABETES ☐ Yes ☐ No If yes, identity type and severity____
Identity any medication taken, name, dosage, and frequency____

8. SEIZURE DISORDER ☐ Yes ☐ No If yes, identity type and severity____
Identity any medication taken, name, dosage, and frequency____

9. Has the candidate ever had any disease, impairment, or abnormality of:

	Yes	No		Yes	No
a) Abdominal organs, digestive system	☐	☐	e) Heart or blood vessels	☐	☐
b) Lungs, respiratory system	☐	☐	f) Tonsils, nose of throat	☐	☐
c) Bones, joints, locomotors system	☐	☐	g) Blood, endocrine system	☐	☐
d) Genitor - urinary system	☐	☐	h) Eyes / vision, ears / hearing	☐	☐

**If yes, please explain (use extra pages if necessary)____

10. Has the candidate been hospitalized? ☐ Yes ☐ No If yes, give date, diagnosis, and outcome for each incident

Continued / 3B

3B
Health Certificate

____

Candidate's name   country

11. Is the candidate currently taking medication or injections (other than those mentioned previously)? ☐ Yes ☐ No
    If yes, identity 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, on emotional, nervous, of eating disorder? ☐ Yes ☐ No
    If you answered yes to either question 12 or 13, AFS may need to contact you for further clarification about the illness or specific problem that you noted.

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? ____

17. Does the candidate wear dental braces? ☐ Yes ☐ No

18. If yes, will orthodontic care be needed while on the program? ☐ Yes ☐ No Frequency? ________________________
    ____

19. 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	☐	________	________	________	________	________
Mumps	☐	________	________	________	________	________
Rubella	☐	________	________	________	________	________
Diphtheria	☐	________	________	________	________	________
Pertussis	☐	________	________	________	________	________
Tetanus	☐	________	________	________	________	________
Poliomyelitis	☐	________	________	________	________	________
BCG	☐	________	________	________	________	________

TB Test which type (circle one) Mantaux or tine? Date_________ Result (+ / -)________

It 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 Forms 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 attesis that you understand and accept the AFS Medical Policies as stated on the Participation Agreement, that the information on Forms 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'S SIGNATURE ____DATE ________________