



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:

Table with 7 columns: YES, DAY/MO/YR, DAY/MO/YR, DAY/MO/YR, DAY/MO/YR, DAY/MO/YR, DAY/MO/YR. Rows include Measles, Mumps, Rubella, Diphtheria, Pertussis, Tetanus, Poliomyelitis, BCG, Hepatitis B, Other.

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: