



# 3a Health Certificate

FOR OFFICE USE

**ID#**

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 \_\_\_\_\_

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"/>		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. \_\_\_\_\_