



# 3b Health Certificate

FOR OFFICE USE

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 exchange 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 exchange program.

Physician Name and Degree

Signature

Address

Date

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

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

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