

People to People Sheboygan Chapter

Student Health Certificate

Please keep a copy of the entire application for your records

Student Name

RELEASE

Our son/daughter has our permission to apply for and take part in the People to People Sheboygan Chapter program. We authorize the doctor to release the information requested and to discuss our son's/daughter's health with representatives of People to People Sheboygan Chapter. We affirm that all of the medical information released to People to People Sheboygan Chapter is complete and truthful to the best of our knowledge. As the applicant's parents or guardians, we agree to authorize the People to People Sheboygan Chapter program or the host family to act for us in any emergency, accident or illness in the event our son/daughter enters the People to People Sheboygan Chapter program. If our son/daughter has a recurrence of any previous illness, condition or anything contracted before leaving home, we, the undersigned, authorize the People to People Sheboygan Chapter program to release our son/daughter to our personal care. We will not hold People to People Sheboygan Chapter responsible for any debts incurred by this or any other illness or condition, and we agree to pay for the return travel of our son/daughter.

Parent's or Guardian's Signature

Date

Student's Signature

Date

STUDENT HEALTH CERTIFICATE

PHYSICIANS, PLEASE NOTE:

This student will participate in an exchange program that involves living overseas with a host family. Please provide detailed information on any condition that could:

- 1) impact the home chosen for the student or his/her adjustment to another culture
- 2) restrict participation in activities; or
- 3) possibly require treatment overseas

Please type or print legibly in BLACK INK and write in English. Upon completion of this form, return it to the student. Thank you for your assistance.

Student Name: _____

Date of Birth: _____

Address:

City

State/Province

ZIP/Postal Code

Date of examination: _____ Age: _____

Sex: M _____ F _____ Height: _____ Weight: _____

Blood Pressure: Svs: _____ Dia: _____ Pulse rate: _____ Regular? Yes ___ No ___

Are reflexes normal? Pupil: Yes _____ No _____ Knee: Yes _____ No _____

Other:

Physician's signature _____ Date: _____

Physician's name printed: _____

Physician's address: _____

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Please mark Yes or No for each of the following to indicate if the student has ever received treatment, attention or advice from a physician or other practitioner for, or been told by any physician or practitioner that such person had:

1. Allergies*	Yes _____ No _____	14. Malaria	Yes _____ No _____
2. Asthma	Yes _____ No _____	15. Measles (Rubella)	Yes _____ No _____
3. Appendicitis	Yes _____ No _____	16. Mumps (Rabula inflans)	Yes _____ No _____
Has appendix been removed?	Yes _____ No _____	17. Pneumonia	Yes _____ No _____
4. Arthritis	Yes _____ No _____	18. Rheumatic fever	Yes _____ No _____
5. Cancer	Yes _____ No _____	19. Scarlet fever	Yes _____ No _____
6. Varicella (Chicken pox)	Yes _____ No _____	20. Serious or persistent cough	Yes _____ No _____
7. Diabetes	Yes _____ No _____	21. Serious or persistent headaches	Yes _____ No _____
8. Eating disorder (e.g. anorexia, bulimia)	Yes _____ No _____	22. Frequent or chronic strep throat (Streptoangina)	Yes _____ No _____
9. Emotional difficulties	Yes _____ No _____	23. Tuberculosis	Yes _____ No _____
10. Enuresis/Bed wetting	Yes _____ No _____	24. Typhoid fever	Yes _____ No _____
11. Epilepsy	Yes _____ No _____	25. Ulcers	Yes _____ No _____
12. German measles (Rubella)	Yes _____ No _____	26. Vertigo, dizziness	Yes _____ No _____
13. Hernia	Yes _____ No _____	Has applicant been operated	Yes _____ No _____
Has applicant been operated on for hernia?	Yes _____ No _____	27. Whooping cough (Pertussis)	Yes _____ No _____
Any disease, impairment or abnormality of:			
a. Blood or endocrine system	Yes _____ No _____	i. Other abdominal organs	Yes _____ No _____
b. Bones, joints, or locomotor system	Yes _____ No _____	j. Ovaries or breasts, if a female	Yes _____ No _____
c. Brain or nervous system	Yes _____ No _____	k. Menstrual disorders, if a female	Yes _____ No _____
d. Ears or hearing	Yes _____ No _____	l. Prostate or testes, if a male	Yes _____ No _____
e. Eyes	Yes _____ No _____	m. Skin	Yes _____ No _____
f. Genital-urinary system	Yes _____ No _____	n. Stomach or digestive system	Yes _____ No _____
g. Heart or blood vessels	Yes _____ No _____	o. Throat	Yes _____ No _____
h. Lungs, respiratory system	Yes _____ No _____	p. Tonsils, nose	Yes _____ No _____
		Have tonsils been removed?	Yes _____ No _____