INTERNATIONAL STUDENT EXCHANGE PROGRAMS

WORLD HERITAGE

CERTIFICATE OF HEALTH

(Please Print)

Dear Physician or Licensed Medical Practitioner:

This student is applying to become an exchange student for an academic year or semester abroad. Please fully complete this form indicating any illness or current/potential health problem(s) that we should be aware of in considering this student for participation in a term abroad as an international exchange student.

Names: _____
Family Given

Address: _____
Street Address

_____
City State/Province Zip/Postal Code Country

Date of Birth: _____/_____/_____ Host Country: _____
Day Month Year

Has the participant had the following illnesses/conditions:

YES	NO		YES	NO	
		Allergies*			Parasites
		Appendicitis			Pneumonia
		Has appendix been removed?			Polio
		Asthma			Rheumatic Fever
		Chicken Pox - If yes, date of illness:____/____/____			Rubella
		Diabetes			Scarlet Fever
		Drug or Alcohol Abuse			Serious or Persistent Cough
		Enuresis			Serious or Persistent Headaches
		Epilepsy			Smallpox
		Hepatitis			Tuberculosis
		Hernia			Typhoid
		Hernia surgery?			Vertigo, Dizziness
		Successfully?			COVID-19 (Explain below)
		Malaria			Significant Other Contagious Diseases
		Measles (Rubeola)			(not mentioned above) _____
		Mumps			

Any disease, impairment, abnormality:

		Blood or Endocrine System			Heart or Blood Vessels
		Bones, Joints or Locomotor System			Lungs, Respiratory System
		Brain or Nervous System			Other Abdominal Organs
		Ears or Hearing			Personality or Behaviour
		Eating disorder			Skin (Acne etc.)
		Eyes or Sight			Stomach or Digestive System
		Genito-Urinary System			Tonsils, Nose or Throat
					Have tonsils been removed?

Please give full information (including dates and details) about every disease or impairment mentioned ("YES" response) for any of the above questions:

_____

_____

*If allergic: To what severity? How is it treated? _____

_____

_____

Sex:_____Height:_____Weight:_____

Pulse Rate:_____Is pulse rhythm normal?_____

Blood pressure: Systolic:_____Diastolic:_____

Are pupillary and knee reflexes normal?_____

What is the participant's vision: Without eyeglasses? OD right:_____OS left:_____

Has the applicant ever been hospitalized? ◯ Yes ◯ No. If yes, please give date, diagnosis and outcome of each illness or accident.

_____

_____

_____

_____

Have you ever consulted one of the following health providers: a neurologist, psychiatrist, psychologist or any other specialist in nervous or psychological disorder? ◯ Yes ◯ No. If so, please explain, which one, when, how long, for what condition/reason.

_____

_____

Does the participant have any health limitations or do you know of any pertinent medical information which is important for the ASSE/WH Program to know which would limit the student's participation in normal school, family, sports and community life? ◯ Yes ◯ No. If yes, please comment fully.

_____

_____

_____

_____

Is the participant currently getting any injections or taking any medication? ◯ Yes ◯ No. If yes, please give name(s) of medication(s) and injections and diagnosis.

_____

_____

_____

Will the participant need any orthodontic care during the coming year? ◯ Yes ◯ No. If yes, attach a statement from the orthodontist, indicating present status, exact care essential to the orthodonture and date care will be completed. (Orthodontic work is **not** covered under ASSE/WH's Medical Insurance).

If the student is female, does she have any problems in connection with her menstruation? If so, please explain how this affects her normal activities.

_____

_____

_____

History of Immunizations/Vaccinations

1. Mandatory Immunizations/Vaccinations/Tests or illness dates

These **are required** by the majority of Host Country High Schools and the ASSE/WH Program prior to departure. Please indicate month, day and year of all Immunizations/Vaccinations (include "boosters") received by participant, the most recent of which must have occurred **within the past 10 years.**

Vaccine/Test	Date (mo/day/yr)	Date (mo/day/yr)	Date (mo/day/yr)	Date (mo/day/yr)	Date (mo/day/yr)
Diptheria	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Polio - Vaccine Type	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Tetanus/Toxoids (Td)	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Pertussis	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Mumps	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Rubella	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Measles (Rubeola)	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Hepatitis B	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Chicken Pox/Varicella	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/____ 4	__/___/___ 5
*Tuberculosis (Mantoux Test)	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
COVID-19 Vaccinations/Booster	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5

*In countries other than the United States, a high percentage of school children are vaccinated with BCG-Vaccine, which is a LIVE vaccine. As a result, some students will have a positive reaction to Mantoux Test for many years.

2. Other Immunizations/Vaccinations

If participant has had any of the following, please indicate the month and year given (Immunizations/Vaccinations below are not required by most Host Country Schools).

Vaccine	Date (mo/day/yr)	Date (mo/day/yr)	Date (mo/day/yr)	Date (mo/day/yr)	Date (mo/day/yr)
Hepatitus A	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Meningitis	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Other	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5
Other	___/___/___ 1	___/___/___ 2	___/___/___ 3	___/___/___ 4	___/___/___ 5

Recommended for general physical activity in school:

☐ Full physical activity including physical education classes (including all sports activities).

☐ Modified physical activity because of _____

If the student is eligible and wishes to participate in the high school's competitive sports program, is there any factor in the student's physical condition which might pose a problem to him/her?_____ If yes, please explain: _____

_____

For Physician:

In my opinion the general state of participant's health is: (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments: _____

_____

_____

I hereby certify that, to the best of my knowledge, the above information is true and correct:

_____ _____

Signature of Physician Date of Examination

_____

Name of Physician (Please print)

_____

Address

_____

_____

Country of License to practice medicine

STAMP

For the Parents/Legal Guardians:

We, the Parent(s) / Legal Guardian(s), consent and authorize ASSE/WH International Student Exchange Programs ("ASSE"/"WH"), or any adult Host Family member to obtain any medical, dental, surgical, psychological, psychiatric, or hospital care, deemed necessary by any health care provider, for the health, treatment and care of this Exchange Student ("Student") during Student's participation in ASSE/WH's Exchange Program. All current and prior significant physical and mental health conditions have been fully disclosed above. We further understand that we are obligated to inform ASSE/WH of any significant changes to the Student's health conditions that may occur after the signature of this document. The Parent(s) / Legal Guardian(s) authorize the health care provider to release all health care records relating to the Student to ASSE/WH.

_____ _____

Signature of Parent or Legal Guardian Signature of Parent or Legal Guardian

_____ _____

Date Date

THIS ASSE/WH STUDENT IS FULLY INSURED FOR ALL NECESSARY AND REASONABLE MEDICAL EXPENSES, ACCIDENTAL INJURY AND DEATH UNLESS RESULTING FROM A PREVIOUSLY EXISTING HEALTH CONDITION.