Culver City Sister City Committee

Student Exchange Program - Certificate of Health

Your Acceptance is contingent on returning this document to CCSCC, fully completed in English by your physician. Please type or print only.

_____

(Print: Last Name) (First Name)

Male ____ Female ____ Age ____

_____

(Address, City, State, Zip)

_____

(Home Phone Number)

Part I To be completed and SIGNED BY APPLICANT'S PARENT BEFORE VISITING THE PHYSICIAN A.

Have you, to the best of your knowledge, ever had any of the following:

(Each item must be "yes" or "no")

Hernia ____ Intestinal Disorder ____ Arthritis ____ Sinusitis ____ Cholera ____ Sciatica ____

Hay Fever ____ Small Pox ____ Rheumatism ____ Asthma ____ Diabetes (1) or (2) ____

Disease of Skin ____ Goiter ____ Typhoid ____ Venereal Disease ____ Cancer ____ Paralysis ____

Mental Illness ____ Fever (type) ____ (_____) Pneumonia ____ Nervous Sys. Disease ____

Stomach Disorder ____ Appendicitis ____ Allergies ____ Bulimia ____ Tuberculosis ____

Disease/Disorder Back ____ Anorexia ____ Rheumatic Fever ____ Disease/Disorder Spine ____

HIV Virus (AIDS) ____ Frequent Colds ____ Disease/Disorder Kidney ____ Eye Disease ____ Tonsillitis ____

Genitourinary Disorder ____ Ear Disease ____ Gall Bladder ____ Prostate Disease ____ Heart Disease ____

Rectal Disease ____ Abnormal Blood Pres. ____

If you have answered "yes" to any of the above, give: (1) specific name of disorder; (2) duration – specify dates; (3) final results. (If none, write "none")

_____

_____

B. During the past five years, when and for what injury, illness or medical disorder (including any of the above or Others) have you been under observation; had medical or surgical advice or treatment; been hospitalized? Give: (1) Specific name of disorder; (2) duration – specify dates; (3) final results. (If none, write "none")

_____

_____

C. To the best of knowledge and belief, are you now in good physical health free from impairment or deformity? Yes _____ No _____ (If no, give specific name of disorder, treatment and present condition)

_____

_____

D. Are you currently taking any injection(s)/medication(s)? Yes___ No ___ If yes, list name(s) and reason(s) for use. _____

_____

I declare that the above statements are true. I understand that reporting false information is justification for rejection of application and/or my being asked to return home.

Signature of applicant/parent: _____

Part II Medical Information

Please be as thorough as possible. This will only be used to help your child be safe and happy during the trip.

Please print

Student: _____ Age ____ Birthdate _____

Health Insurance Provider _____

Group Number _____ Subscriber No. _____

Does your provider have coverage outside of the U.S.A.? Any special requirements or things you/we need to obtain for them from the doctor or hospital?

_____

_____

Does your child take any regular prescription medications?

_____

If so, for what?

_____

Does your child have any health problems the chaperone and or host family needs to be aware of?

_____

If a daughter, has she started menstruation? _____ If not, is she prepared? _____

Date of last tetanus shot: _____ Flu immunization: _____

Dates of COVID Vaccinations: _____

Does your child have any allergies or sensitivities that the chaperone or host family needs to be aware of?

If so, please be specific as to the allergy/sensitivity and if they take medication_____

_____

Students should bring over the counter medications for headache, upset stomach, etc. Please check the Internet for particular medicines or medical supplies forbidden to transport into the country without a physician's letter. In the event that your child is on a daytrip and does not have his/her meds., do the chaperones have permission to give your child such medications as Tylenol, Pepto Bismol, etc.?

Please indicate your preferences:

_____

Please share any other medical history or information about your child:

_____

_____

_____

Parent/Guardian's signature / Date

_____

Parent/Guardian's signature / Date

Part III – To be completed, signed and returned by your physician

Please provide an addressed and stamped envelope to the address on the bottom of the form

The student listed below is being considered as a delegate for an international exchange visit and is required to provide the information listed below.

Student's Name:

_____

Student's Address & Phone Number:

_____

_____

A. Insert height and weight, for the rest, enter "N" if normal. Enter "AB" if abnormal and describe in detail under remarks.

Height _____ Head _____ Hernia _____ Weight _____ Nose _____ Reflexes _____ Eyes _____

Rectum _____ Heart _____ Ears _____ Pharynx _____ Abdomen _____ Neck _____

Lungs/Clear? _____

Comments:

_____

_____

B. Has the applicant ever suffered from any nervous or mental disorders?

_____

_____

C. Does the applicant show any sign of communicable diseases, over fatigue or physical defects?

Yes____ No ____

D. In my opinion, the applicant's health and physical condition are: Good _____ Fair _____ Poor _____
Remarks: Describe any abnormalities noted in Part II – A, B, C or D and add any other comments:

_____

_____

_____

_____

Name & title of Physician (Print) _____

Date _____

License No. _____

Address _____

Signature _____

Please mail completed confidential document to: Culver City Sister City Committee, Inc. Student Exchange Program/Chairperson, P. O. Box 1072 Culver City, California 90232