CERTIFICATE OF HEALTH -INBOUND GERMANY

(Please write in capital letters)

Dear Physician or Licensed Medical Practitioner,

This student is applying to become an exchange student. 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 program in Germany as an international exchange student.

Full Name _____

Date of Birth (dd/mm/yyyy) _____

Has the participant had the following illnesses/condition:

YES	NO			YES	NO	
❒	❒	Allergies*		❒	❒	Parasites
❒	❒	Appendicitis ❒ Appendix has been removed		❒	❒	Pneumonia
❒	❒	Asthma		❒	❒	Polio
❒	❒	Chicken Pox		❒	❒	Rheumatic Fever
❒	❒	Diabetes		❒	❒	Rubella
❒	❒	Drugs or Alcohol abuse		❒	❒	Scarlet Fever
❒	❒	Enuresis		❒	❒	Serious or Persistent Cough
❒	❒	Epilepsy		❒	❒	Serious or Persistent Headaches
❒	❒	Hepatitis		❒	❒	Smallpox
❒	❒	Hernia ❒ successfully operated		❒	❒	Tuberculosis
❒	❒	Malaria		❒	❒	Typhoid
❒	❒	Measles (Rubeola)		❒	❒	Vertigo, Dizziness
❒	❒	Mumps		❒	❒	Significant Other Contagious Diseases (not mentioned above)
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 Behavior
❒	❒	Eating Disorder		❒	❒	Skin (Acne etc.)
❒	❒	Eyes or Sight		❒	❒	Stomach or Digestive System
❒	❒	Genito-Urinary System		❒	❒	Tonsils, Nose or Throat Tonsils ❒ have been removed

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

_____

_____

_____

*If allergic: to what, how severe, how is it treated? _____

_____

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

_____

_____

Has the applicant ever consulted one of the following health providers: a neurologist, psychiatrist, psychologist or any other specialist in nervous or psychological disorder? ❒ Yes ❒ No If yes, please explain.

_____

_____

Does the participant have any health limitations or do you know of any pertinent medical information which is important to know, which would limit the student's participation in normal school, family, sports and community life? (this also includes attention and concentration issues such as ADHD – even without a formal diagnosis – as well as psychological stress, etc.) ❒ Yes ❒ No If yes, please explain.

_____

_____

Is the participant currently getting any injections or taking any medication? ❒ Yes ❒ No If yes, please give names of medications 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 orthodontic and date care will be completed (orthodontic work is usually **not** covered by the 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

   Please indicate month and year of all immunization / Vaccination (include "boosters") received by participant, the most recent of which must have occurred within the past 10 years.

Vaccine	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)	Date (dd/mm/yyyy)
Diptheria	_____	_____	_____	_____	_____
Polio – Vaccine type	_____	_____	_____	_____	_____
Tetanus/Toxoids (TD)	_____	_____	_____	_____	_____
Pertussis	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Rubella	_____	_____	_____	_____	_____
Measles (Rubeola)	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
Chicken Pox/Varicella	_____	_____	_____	_____	_____

Recommended for general physical activity in school:

○ Full physical activity including physical education classes (including sports activities)

○ Modified physical activity because of _____

Name of Physician _____

Signature _____

Date _____ Stamp_____