5. Statement of Applicant Health

Applicant Name: _____

Date of Examination: _____

Height: _____ Weight: _____ Blood Type (If known): _____

Physician must answer each of the following questions.

To be completed by attending physician. (Each of the following listed items MUST be circled "yes" or "no". Please do not leave any blank).

Has the applicant ever:

Had any of the following:			**Had any of the following:**			**Any disease, impair-ment, abnormality of:**		
Allergies to Drugs	Yes	No	Hepatitis	Yes	No	Blood, Endocrine System	Yes	No
Food Allergies	Yes	No	Hernia	Yes	No	Bones, Joints, Locomotor System	Yes	No
Pet Allergies	Yes	No	Learning or Speech Defect	Yes	No	Brain, Nervous System	Yes	No
Smoke Allergies	Yes	No	Malaria	Yes	No	Digestive System/Abdominal Organs	Yes	No
Appendicitis	Yes	No	Measles (Rubeola)	Yes	No	Ears or Hearing	Yes	No
Asthma	Yes	No	Parasites (intestinal, other)	Yes	No	Eyes or Vision	Yes	No
Cough (persistent, recurring)	Yes	No	Rheumatic Fever	Yes	No	Genito-Urinary System	Yes	No
Diabetes	Yes	No	Rubella	Yes	No	Heart or Blood Vessels	Yes	No
Eating Disorder	Yes	No	Scarlet Fever	Yes	No	Respiratory System, Lungs	Yes	No
Enuresis	Yes	No	Seizure Disorder	Yes	No	Skin (Acne, etc.)	Yes	No
Goiter (Struma)	Yes	No	Sleepwalking	Yes	No	Tonsils, Nose, or Throat	Yes	No
Headache (persistent)	Yes	No	Vertigo, Dizziness	Yes	No	Varicose Veins	Yes	No

If “Yes”, was checked for any of the above, physician must provide full details and dates of treatment:

_____

_____

_____

_____

_____

To be completed by attending physician. (Each of the following listed items MUST be circled “yes” or “no”. Please do not leave any blank).

Has student ever been hospitalized? Yes No
If yes, please provide date and reason: _____

Has the applicant ever been had surgery? Yes No
If yes, please provide date and reason: _____

Has applicant ever been advised to have surgery which has not been done? Yes No
If yes, please provide date and reason: _____

Has applicant ever consulted a neurologist, psychiatrist, psychologist, or any other specialist in nervous or emotional disorders? Yes No
If yes, please complete Health Addendum.

When and for what reason did the student last consult a physician? _____
_____

Should the student be restricted from any type of physical activity? Yes No
If yes, please explain: _____

What diseases, ailments, or injuries has the student had in the last year?

Allergy: Mild Moderate Severe Treatment required: _____

_____

Allergy: Mild Moderate Severe Treatment required: _____

_____

Allergy: Mild Moderate Severe Treatment required: _____

_____

To be completed by attending physician, not applicant or family member.

Please indicate any medication the applicant is currently taking and the purpose of using these drugs. (Note: when applicant studies abroad, a supply of medication should be provided in clearly labeled containers indicating the drug's generic name.)

Medication:_____Purpose:_____Dosage:_____
Student will take in U.S.? Yes No

Medication:_____Purpose:_____Dosage:_____
Student will take in U.S.? Yes No

Medication:_____Purpose:_____Dosage:_____
Student will take in U.S.? Yes No

If there are any drugs (prescription or nonprescription) that should not be administered, please list them here.

_____

_____

_____

Please indicate any other pertinent medical information that may have been omitted. (Such as abnormal blood pressure, weight problems, etc.)

IMMUNIZATION RECORD

Pupils enrolled in kindergarten through grade 12 in the US are required to have written proof on file at their public or nonpublic school that they have been immunized against DTP (diphtheria, tetanus, pertussis), poliomyelitis, measles, mumps, rubella, and hepatitis B. Failure to do so is cause for exclusion from school. Additional immunizations requirements vary by state and student may also need to provide written proof of Hepatitis A and Meningococcal vaccinations.

1. Polio (Trivalent-Oral-TOPV), three or more doses of trivalent oral polio vaccine (TOPV) (An additional dose is required if last dose was received before the age of four years)
2. Diphtheria-tetanus-pertussis (DTP) or diphtheria-tetanus (TD), four or more doses of DPT, DT (pediatric) or TD (adult) vaccine or a combination thereof, including a booster within the past 10 years. Booster within the past 10 years must include Pertussis (TDaP)
3. Measles (rubeola, ten-day measles), two doses, or physician-verified disease
4. Rubella (three-day measles), two doses, or physician-verified disease
5. Mumps vaccine, two doses, or physician-verified disease
6. TB test, or chest x-ray, must be within 12 months of student's arrival
7. Hepatitis-B, three doses
8. Chicken Pox (Varicella), two doses
9. Hepatitis A, 2 doses (state dependent)
10. Meningococcal (state dependent)

Please indicate the vaccine and date each dose was given. Do not use brackets ({,}) or quotation marks (“) to complete the chart—each vaccination date must be written out in the space provided in month/day/year format.

Vaccine	1st Dose mm/dd/yyyy	2nd Dose mm/dd/yyyy	3rd Dose mm/dd/yyyy	4th Dose mm/dd/yyyy	Most Recent * Dose mm/dd/yyyy
Polio (TOPV)					
Hepatitis B					
DPT and/or TD and/or TDaP (diphtheria, tetanus, and pertussis or whooping cough and/or tetanus and diphtheria only)					

*Circle most recent vaccine type: DPT / TD / TDaP

Vaccine	1st Dose mm/dd/yyyy	2nd Dose mm/dd/yyyy	Most Recent mm/dd/yyyy	OR	Date of Illness mm/dd/yyyy
Measles (rubeola—10 day, red measles)				OR	
Rubella (German measles—3 day, measles)				OR	
Mumps				OR	
Chicken Pox				OR	
Hepatitis A				OR	
Meningococcal				OR	

	Result (+ or -)	Date Administered	Date Results Read		
Tuberculin skin test					
	Result (+ or-)	Date of X-ray			
If positive, report of negative X-ray & copy required					

1 Union Street, Suite 202
Portland, Maine 04101
+1.207.871.8622

Please circle your opinion of the state of the candidate's health:

Excellent Good Fair Poor

I, the undersigned, have reviewed the medical history of the applicant and given a thorough physical examination, certify that all important medical information has been noted on this form and that nothing relevant has been omitted, and state that I am not a family relation of the applicant examined.

Physician's Name (printed): _____

Physician's Signature: _____

Physician's Address: _____

_____

_____

Date (mm/dd/yyyy): _____

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