STUDENT HEALTH RECORD AND MEDICAL RELEASE

Medical Information

Medical information to be completed by Physician.

Student's Name: _____ Date of Birth: _____
Mo. Day Year

Physical Examination

Sex _____ Hair Color _____ Eye Color _____ Height (cm) _____ Weight (kg) _____

Visual Acuity: (Right) _____ (Left) _____ Hearing: (Right) _____ (Left) _____

Blood Pressure: _____/_____ Pulse: _____/min.

Immunizations Dates Administered (Mo./Day/Yr – Booster Required within Past 10 Years)

	1st	2nd	3rd	4th
DPT (Diphtheria, Pertussis, Tetanus)	____/____/____	____/____/____	____/____/____	____/____/____
MMR (Mumps, Measles, Rubella)	____/____/____	____/____/____	____/____/____	____/____/____
TOPV (Polio)	____/____/____	____/____/____	____/____/____	____/____/____
Hepatitis B	____/____/____	____/____/____	____/____/____	____/____/____
Varicella (Chicken Pox)	____/____/____	____/____/____	____/____/____	____/____/____

Tuberculin Skin Test _____/_____/_____ Results: Positive ☐ Negative ☐

HIV Test _____/_____/_____ Results: Positive ☐ Negative ☐

Medical History (Disorders, Infections, Conditions)

	Yes / No		Yes / No		Yes /No	
Digestive	☐	☐	Muscular	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Eyes	☐	☐	Pertussis	☐	☐
Asthma	☐	☐	Neurological	☐	☐	Diphtheria	☐	☐
Allergies	☐	☐	Cardiac	☐	☐	Chicken Pox	☐	☐
Mumps	☐	☐	Congenital	☐	☐	Appendicitis	☐	☐
Rubella	☐	☐	Pneumonia	☐	☐	Measles	☐	☐
Kidney	☐	☐	Hospitalization	☐	☐	Hepatitis	☐	☐
Malaria	☐	☐	Operation	☐	☐	Convulsion	☐	☐

Please provide details of any above conditions affecting the applicant (dates, lasting effect, medication, ongoing treatment):

_____

_____

_____

_____

Allergies (food or medication sensitivity, symptoms, treatment and/or expected future treatment):

_____

_____

Does the applicant take any medication, vitamins or dietary supplements regularly and/or periodically? If yes, please describe.

_____

_____

How often is medication administered? _____ Purpose of medication: _____

Has the applicant ever undergone surgery? _____ If yes, please describe: _____

_____

Are there any restrictions on the applicant's physical activity such as physical education and sports?

_____

In your opinion, what is the general condition of the applicant's health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please explain: _____

Physician's Statement

I, the undersigned physician, have reviewed the medical history of the applicant, given a thorough medical examination, and certify that all medical information on this form is correct and that no relevant information has been omitted.

_____ _____ _____

Physician's Signature Date Physician's Stamp

Physician's Name (Printed) _____

Address _____

City _____ State/Province _____ Postal Code _____ Country _____

Parent's Medical Release

Medical Release/Authorization to be completed by Parents/Guardian.

We, as Parents/Guardians of the undersigned student, do hereby authorize LPI Learning and the American sponsoring Host Parents, as agents of the undersigned Parents/Guardians, to consent to any X-ray examinations, anesthetic, medical or surgical diagnosis, or treatment or hospital care which is deemed advisable by and is rendered under the general supervision of any licensed physician or surgeon at a hospital. It is understood that this authorization is not given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the aforesaid agents to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician or surgeon, in the exercise of his/her best judgment, may deem advisable.

Student's Name (Print): _____ Date: _____

Student's Signature: _____

Father's/Guardian's Name (Print): _____ Date: _____

Father's/Guardian's Signature: _____

Mother's/Guardian's Name (Print): _____ Date: _____

Mother's/Guardian's Signature: _____