J1 Participant Health Screening

(To be completed by Applicant)

Last Name	First Name	Date of Birth (MM/DD/YYYY)
_____	_____	_____

Gender: Male Female Height: _____ (in Feet and Inches) Weight: _____ (in Pounds)

Health History

(Check all that apply)

☐ Anemia	☐ Dizziness/Fainting	☐ Heart Disease	☐ Mumps
☐ Anorexia	☐ Ear Infection	☐ Hepatitis A/B/C	☐ Pregnancy
☐ Arthritis	☐ Epilepsy/ Seizures	☐ Kidney Disease	☐ Rheumatic Fever
☐ Asthma	☐ Eye Problems	☐ Malaria	☐ Scarlet Fever
☐ Bulimia	☐ Gallbladder Problems	☐ Measles	☐ Tuberculosis
☐ Chicken Pox	☐ German Measles	☐ Menstrual Problems	☐ Ulcers
☐ Depression	☐ Glandular Fever	☐ Migraine/ Headaches	☐ Venereal Disease
☐ Diabetes	☐ Other		

If you check any of the above, please give details (including dates) on a separate sheet of paper.

Place a check mark next to following organs or systems if there any known abnormalities?

☐ Cardiovascular	☐ Head, ears ,nose, throat	☐ Reproductive	☐ Metabolic
☐ Respiratory	☐ Eyes (including glasses or contacts)	☐ Gastrointestinal	☐ Skin
☐ Genitourinary	☐ Musculoskeletal	☐ Nervous	☐ Other

If you check any of the above, please give details (including dates) on a separate sheet of paper.

Do you suffer from any allergies?

Allergies	Describe reaction:	Management or treatment:
☐ Hay Fever		
☐ Insect Sting		
☐ Penicillin		
☐ Other drugs		
☐ Other:		

General Questions:

Is your physical activity restricted in any way? Yes No Do you have any dietary restrictions? Yes No

Do you have a chronic or recurring illness? Yes No Are you currently taking any medications? Yes No

Have you ever been treated by a psychiatrist? Yes No Have you ever undergone surgery? Yes No

Have you ever received treatment for a nervous or emotional issue? Yes No

If you answered yes to any of these general questions please give full details on a separate sheet of paper.

Emergency Contact **Must speak English**

Name: _____ Relationship to Applicant: _____

Email: _____ Telephone: _____

Are you covered by a different insurance than that provided by your sponsor? Yes No

If you answered yes, please give details:

Carrier Name: _____ Contact Phone Number: _____

Carrier/Plan Number: _____ Group or Policy Number: _____

I certify that all information given is true to the best of my knowledge, and I hereby give permission for emergency medical care should it be necessary.

Signature	**Date (MM/DD/YYYY)**
_____	_____

J1 Participant Health Screening

(To be completed by Physician)

Last Name	First Name	Date of Birth (MM/DD/YYYY)

As an Exchange Visitor in the U.S., the above referenced applicant will be living with and responsible for young children. It is therefore important that we are advised of any physical or mental health problems that may have a bearing on the applicant's ability to participate.

Please review the information provided by the applicant on Page 1 of this form and answer the following questions.

The above named applicant is in good physical condition. Yes No

The above named applicant does NOT have any physical or emotional issues that would negatively affect his/her work as a camp counselor/support staff at a US summer camp. Yes No

Comments:

Please check whether the applicant had been immunized against the following and provide the date of immunization:

☐ Chicken Pox (Varicella) Date	☐ Hepatitis B Date	☐ TP Mantoux test Date	☐ Diphtheria Date
☐ Haemophilus InfluenzaeB Date	☐ Tetanus Date	☐ Mumps Date	☐ Typhoid Date
☐ German Measles (Rubella) Date	☐ Measles Date	☐ Polio Date	☐ Whooping Cough Date

Signature of Licensed Medical Personnel	Date (MM/DD/YYYY)
Printed Name	Title
Telephone	Email