Department of State Academic Exchanges
Participant Medical History and Examination Form

Having been selected to participate in a U.S. Department of State educational exchange program, you are required to submit a completed Medical History and Examination Form. The attached form should be completed and returned to:

Fulbright grantees from Finland should return the form to the Fulbright Center, Helsinki, Finland
Please scan/copy the signed document and send it by e-mail /mail to your program coordinator at the Fulbright Center.
Retain the original in your personal files.

You should complete Part I prior to the medical examination. Part II, the "Health History" and Part III, "Medical Examination" must be completed by a qualified, licensed doctor or physician no more than six months before your grant start date.

The purpose of these forms is to confirm health status for review and medical clearance, upon which a grant is contingent. The information will also help your program staff be of maximum assistance to you should the need arise while you are on a grant. Mild physical or psychological disorders can become serious under the stresses of life in an unfamiliar environment. It is important that we be made aware of any medical, emotional or psychological problems, past or current, which might affect you while on your program.

The Medical Information Form and Physician's Statement should be completed in English by a licensed physician, doctor (MD, DO, or foreign equivalent), or nurse practitioner who is not a member of your family and mailed to your program staff before your participation in the program can be confirmed. Violation of this policy will result in the revocation of your award. If the forms are completed by a health practitioner who is not an MD, DO, or nurse practitioner, it must be cosigned by an MD or DO. Your award is contingent upon your submitting the Medical Information Form and Physician's Statement to your program staff by stated deadlines, and remains contingent until the information is reviewed and medical clearance is issued.

INSTRUCTIONS TO PROSPECTIVE GRANTEES

In advance of your medical examination:

- Complete Part I on your own prior to the physical examination
- Sign and date the form on page 8.
- Familiarize yourself with the instructions to the physician.
- Understand the scope of the clinical examination and the tests required for your age and/or known condition so that you can be sure that the requirements of the form will be met.

At the time of your medical examination*:*

- Assure that your health is evaluated in SECTIONS II AND III and that the form is signed by a physician. (Although physicians' offices sometimes use a physician's assistant or R.N. to help perform the examination and tests, only a physician or a nurse practitioner may sign the form.)
- Ask your physician to mail the completed form and test results to you as soon as possible. (If the form is incomplete or if the results of the required tests are not reported, your program staff will return the form to you. This step costs time and may require a return visit to the physician. Please prevent such delays.)

PART I: TO BE COMPLETED BY PROSPECTIVE GRANTEE. *Please type or print in ink*

NAME: _____ *Last* *First* *Other*	
DATE OF BIRTH: _____ *Month/Day/Year*	SEX: ☐ Male ☐ Female
PRESENT ADDRESS: _____ *Home or Residence* *City* *Country*	
GRANT LOCATION: _____ (If known) *City/ Country*	GRANT DATES: _____ *From* *To*

Will you be covered by private health insurance while on your program? If yes, complete the following information. As well, please confirm with your provider that your coverage extends to your time overseas for your award. Be aware your existing coverage will remain your primary insurance for the duration of your grant.

Name of Health Plan/ Health Care Provider:	
Health Plan ID#:	
Health Plan Effective Date:	
Health Care Provider Address:	

Names of medical professionals consulted within the last 3 years, except for routine physical examinations. List your primary care physician as well as any specialists. *(Submit an additional form as needed).*

NAME	SPECIALTY or Primary Care	TELEPHONE #:
	Primary Care Physician	

EMERGENCY CONTACT INFORMATION and MEDICAL PROXY

Name two individuals who could be notified in case of emergency.

PRIMARY EMERGENCY CONTACT:	**SECONDARY EMERGENCY CONTACT:**
Name:	Name:
Address:	Address:
Cell phone number:	Cell phone number:
Home number:	Home number:
Office number:	Office number:
Email:	Email:

While your academic exchange program does not require that you have established a medical proxy – a medical proxy is an individual who is informed of and can make decisions about your medical wishes on your behalf if you are unable – it is strongly recommended that you consider this option for any emergency medical situations that may result while you are abroad. Should you already have a designated medical proxy, please indicate him/her below and provide a copy of the documentation along with your medical examination results.

If you have a legal medical proxy, indicate him/her here and provide a copy of documentation. (Most U.S. states have forms for the purpose of designating a medical proxy):

MEDICAL PROXY CONTACT (*Optional*):
Name:
Address:
Cell phone number:
Home number:
Office number:
Email:

INSTRUCTIONS FOR THE EXAMINING PHYSICIAN

The individual you are examining is a candidate for an academic exchange program who will reside in another country. Some locations are remote and may have limited medical support from doctors, nurses, laboratory facilities and hospitals.

Please evaluate thoroughly all items listed on the examination form. It is most important that you:

1. Comment on all items checked "yes" on the Medical History section (below).
2. Record all physical findings after completing the examination as requested. *Only the results of a physical exam performed no more than six months prior to the grant start date may be reported.*
3. Order and record (or attach copies of) all relevant laboratory tests or necessary data. It is important that all of the tests be reported as requested for the age or condition of the examinee. If there are test results within the past six months, please attach those.
4. Comment on all indicated follow-up examinations and conditions that may require frequent observation or prolonged treatment. Please indicate your overall opinion of the examinee's health in items (page 8).
5. Sign and date the portion of the examination form that you completed (page 8).

PART II: TO BE COMPLETED BY PHYSICIAN

To be completed by the grantee's physician in consultation with the candidate to determine what tests, if any, may be required. For any items checked "Yes," the physician may recommend a test to allow for further explanation of the current status of the condition and/or the prognosis or outcome.

MEDICAL HISTORY					
Does the grantee now have or have they ever had any of the conditions or symptoms listed below? Indicate "YES" or "NO". "YES" answers MUST be explained in the space provided following this section.					
CHECK EACH ITEM	**YES**	**NO**		**YES**	**NO**
Frequent or severe headaches			Fainting spells (syncope)		
Epilepsy or seizures			Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure		
Stroke			Eye disease or vision impairment (other than corrected refractive error)		
Hearing impairment			Severe allergies, including environmental, insect stings, food, and medication		
Tooth or gum disease (periodontal disease)			Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.).		
Asthma, emphysema, persistent cough, or other lung conditions.			Depression, anxiety, excessive worry, schizophrenia, psychosis		
Tuberculosis			Drug or alcohol abuse		
High blood pressure			Sickle cell anemia, excessive bleeding, blood clots or other blood disorder		
Gynecological disorder			Cancer in any form		
Other hormonal disorders, incl. thyroid			HIV infection, AIDS		
Diabetes mellitus (high blood sugar, sugar in urine)			Severe skin disorder		

PART III. PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

If the grantee answered "YES" to any of the above, please explain in detail, including dates of occurrence, treatment and outcome.

Has the grantee ever had any significant or serious illness or injury not mentioned above? If so, explain the nature of the problem and outcomes.
Please explain any operations (surgical procedures) the grantee has had, including dates and major complications.
Has the grantee ever been hospitalized for any reason? If so, explain what condition, provide dates, and explain the outcome.
Has the grantee ever seen a psychiatrist, psychologist, or psychotherapist? If so, explain for what condition and provide dates of treatment and explain the outcome.
List all the medications taken by the grantee in the past three (3) years.
List all specific medications (generic or name brand) currently being taken by the grantee, whether on a regular or as needed basis.
List all medical devices being used by the grantee (for example: insulin pump, prostheses, nebulizers).

Note: Results of tests and x-rays included in this medical evaluation must be no more than six months prior to the date of the participant's arrival in or departure from the United States.

MEDICAL EXAMINATION FORM

THIS PHYSICAL EXAMINATION FORM MUST BE COMPLETED IN ENGLISH BY A DESIGNATED AND QUALIFIED PHYSICIAN AFTER REVIEWING THE EXAMINEE'S MEDICAL HISTORY (PART I), CONDUCTING A PHYSICAL EXAMINATION, AND ASSESSING LABORATORY AND X-RAY RESULTS. THE EXAMINING PHYSICIAN MUST COMMENT ON ALL POSITIVE AND/OR SIGNIFICANT FINDINGS AND SIGN WHERE INDICATED.
PLEASE TYPE OR PRINT IN INK

APPLICANT'S NAME: _____
Last *First* *Other*

HEIGHT: _____ *(in or cm)*

WEIGHT: _____ *(lb or kg)*

BLOOD PRESSURE: _____ *Syst. /diast.*

RESTING HEART RATE:_____

CLINICAL EVALUATION

Please provide an answer to each item.
Abnormal findings must be fully explained in the space provided.

	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
Head and neck			
Hearing Acuity			
Visual Acuity (with corrective lenses, if used)			
Lungs and chest			
Heart and vascular system			
Abdomen			
Breasts			
Genitourinary/Gynecologic			
Musculoskeletal			
Lymphatic			
Neurologic			
Skin			
Psychiatric			

A test for tuberculosis is required within six months of the physical examination, regardless of prior BCG vaccination. The PPD skin test or interferon gamma release assay blood test is acceptable. PPD skin test results over 10mm require a chest X-ray. An abnormal result on either test mandates a chest X-ray to evaluate for active tuberculosis.

Tuberculin Skin Test (PPD) Result (millimeters of induration): _____ ☐ **Pos** ☐ **Neg**

Date of test: _____
OR
IGRA Test Date: _____ ☐ **Pos** ☐ **Neg**

Chest X-ray (if required) Date: _____

Chest X-ray findings:
(Note to Physician: X-ray images need not be submitted on film or otherwise)

There are no specific laboratory tests required, although the exchange program may request further testing based on an applicant's medical history. Physicians are encouraged to obtain appropriate tests as indicated by the medical history and results of the physical examination or place of grant activity (e.g., G6PD for malarial areas). For example, a diabetic patient should have a recent blood sugar determination or patients with HIV infection should obtain a CD4 count.

NOTE: IT IS THE GRANTEE'S RESPONSIBILITY TO DETERMINE ANY TEST SPECIFICALLY REQUIRED BY HIS/HER HOST COUNTRY.

VACCINATIONS

POLIO (Three or more doses)	**Dates of immunization:**
DIPHTHERIA, PERTUSSIS, TETANUS (Three or more doses, one within the past 10 years)	**Dates of immunization:**
Measles – Mumps – Rubella (MMR) **(Or list individual Measles, Mumps, and Rubella immunizations below)**	**Date of Immunization:**

MEASLES **Dates of Live Immunization** (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of measles titer**	**First immunization date:** **Second immunization date:** **(or) Date of Disease:** **(or) Date and result of measles titer:**
MUMPS **Dates of Immunization** (two required, at least one month apart) **(or) Indicate date of disease** **(or) Indicate date and results of mumps titer**	**First immunization date:** **Second immunization date:** **(or) Date of Disease:** **(or) Date and result of mumps titer:**
RUBELLA **Dates of Immunization** (two required, at least one month apart) **(or) Indicate date and results of rubella titer** ***Note**: History of disease is not acceptable proof of immunity to rubella*	**First immunization date:** **Second immunization date:** **(or) Date and result of rubella titer:**

PHYSICIAN'S STATEMENT:

Based on your physical examination and on the candidate's physical and emotional history, do you consider the examinee physically and emotionally able to study, teach or conduct research in the country indicated on page 2 of the form? (Circle one) **Yes or No**

If No, please explain:

PERSON COMPLETING THE PHYSICAL EXAMINATION:

Name	Position	Date

Signature of Examining /Supervising Physician:

_____**Date**:_____

Typed Name of Examining /Supervising Physician

_____**Telephone#**:_____

Address_____

PARTICIPANT'S STATEMENT:

I certify that I have reviewed the information supplied by me in Part I and to my physician in Part II and that it is true and complete to the best of my knowledge. In the event of a serious illness or medical emergency during the grant activity, I authorize release of my medical records to the U.S. Department of State or its designated contractual agency. I am aware that the information in this form and any attachments, i.e., test results, etc. are being provided to my supervising agency as part of the medical clearance process. I acknowledge that falsifying or knowingly excluding critical medical information may jeopardize my program participation.

I understand that if any of this information is found to be substantially inaccurate or incomplete, it may be grounds for termination of my grant and my return home.

Signature: _____**Date**:_____

Privacy Policy: The information provided by you and your physician(s) will remain confidential and will be shared with your program staff or appropriate professionals for grant administration purposes only.

Revision date: March 23, 2012
ECA/A/E