AFS Health Certificate

Physician. Complete and sign this form. The applicant's physician should not be related to the applicant. AFS is asking for this information to help us provide a safe and appropriate placement for the applicant. AFS reserves the right to ask for further information to determine if the applicant meets the program medical qualifications.

Applicant and Parent/Guardian. Both applicant and parent/guardian must sign this form. We are asking for you to provide us the information below to help us provide a safe and appropriate placement for you. Your host family and the hosting AFS organization will need to have a good understanding of your condition, if any.

1. Medical History

To be completed by physician. For Yes responses, please provide a detailed explanation here or attached in a separate report.

APPLICANT NAME			HOME COUNTRY
BIRTH DATE (DD/MM/YY)		HEIGHT	WEIGHT

ABNORMALITIES Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration?	◯ No	◯ Yes	IF YES, PLEASE DESCRIBE:
ALLERGIES	◯ No	◯ Yes	IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:
ASTHMA	◯ No	◯ Yes	IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:
DIABETES	◯ No	◯ Yes	IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:
SEVERE ACNE REQUIRING MEDICAL MONITORING	◯ No	◯ Yes	IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:
SEIZURE DISORDER	◯ No	◯ Yes	IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:
SURGICAL PROCEDURES	◯ No	◯ Yes	IF YES, LIST PROCEDURE, DATE, DIAGNOSIS, PROGNOSIS, AND OUTCOME FOR EACH PROCEDURE.
LIMITED OR RESTRICTED ACTIVITIES Are there any health limitations or restrictions on the applicant's activities and/or sports participation, or any medical information which should be considered for a home/school placement?	◯ No	◯ Yes	IF YES, PLEASE DESCRIBE:
HOSPITALIZATION Has the candidate been hospitalized within the last two years?	◯ No	◯ Yes	IF YES, PLEASE ATTACH REPORT AND/OR OVERVIEW OF DIAGNOSIS AND OUTCOME FOR EACH.

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DISEASE/CONDITIONS
Has the applicant HAD any of the diseases/conditions listed below or any other significant medical background which may be important to providing a safe experience for the applicant?

POLIOMYELITIS	◯ No	◯ Yes
TUBERCULOSIS	◯ No	◯ Yes
OTHER	◯ No	◯ Yes

IF YES, GIVE DETAILED INFORMATION AND DATES (USE EXTRA PAGES IF NECESSARY):

DISEASE, IMPAIRMENT, OR ABNORMALITY
Has the applicant ever had any disease, impairment or abnormalities listed below. If yes, please explain.

ABDOMINAL ORGANS, DIGESTIVE SYSTEM	◯ No	◯ Yes	BONES, JOINTS, LOCOMOTOR SYSTEM	◯ No	◯ Yes
HEART BLOOD VESSELS	◯ No	◯ Yes	BLOOD, ENDOCRINE SYSTEM	◯ No	◯ Yes
LUNGS, RESPIRATORY SYSTEM	◯ No	◯ Yes	GENITO-URINARY SYSTEM	◯ No	◯ Yes
TONSILS, NOSE OR THROAT	◯ No	◯ Yes	EYES/VISION, EAR/HEARING	◯ No	◯ Yes

IF YES, PLEASE EXPLAIN (USE EXTRA PAGES IF NECESSARY):

NERVOUS, EMOTIONAL, PSYCHOLOGICAL, OR EATING DISORDER

Has the applicant EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder?

◯ No ◯ Yes

Is there a history of, or present evidence of, an emotional, nervous or eating disorder?

◯ No ◯ Yes

If Yes to either specific question above, a FULL report by the specialist, including diagnosis, any medication taken, name, dosage & frequency, and treatment dates, and a statement by the candidate about the illness or specific problem must be attached.

Note: Placement in a foreign host family, school and community requires adjustment which often involves emotional stress. It will not be a time for relaxation or temporary relief from any current therapy. If the applicant is experiencing current emotional, physical, personal or family difficulties, these difficulties can be severely exacerbated by the adjustment demands of the AFS program. Therefore, you are requested to evaluate carefully the applicant's current or previous condition and treatment along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment.

CELIAC DISEASE
Does the applicant have celiac disease? ◯ No ◯ Yes

IF YES, IDENTIFY THE MEDICATION, REASON FOR USAGE, DOSAGE AND FREQUENCY:

If the applicant eats gluten, would it create a dangerous situation for his/her health? ◯ No ◯ Yes

Has the applicant ever been hospitalized because of complications related to celiac disease? ◯ No ◯ Yes

Will the applicant need to visit a doctor while on program to manage the condition? ◯ No ◯ Yes

ADDITIONAL MEDICATIONS
Is the applicant currently taking medication or injections (other than those mentioned previously)? ◯ No ◯ Yes

IF YES, IDENTIFY THE MEDICATION, REASON FOR USAGE, DOSAGE AND FREQUENCY:

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2. Immunizations

To be completed by physician. AFS recommends you discuss destination with the applicant to determine if additional immunizations are recommended. The AFS office in the hosting country will notify the applicant of any additional immunizations required for entrance to the country and/or entrance to school.

Please specify exact day, month and year (DD/MM/YY) that the applicant had the following immunizations:

	DOSE 1 DATE	DOSE 2 DATE	DOSE 3 DATE	DOSE 4 DATE / INFO
☐ MEASLES				
☐ MUMPS				
☐ RUBELLA				
☐ HEPATITIS A				
☐ HEPATITIS B				
☐ DIPHTHERIA				
☐ TETANUS				
☐ PERTUSSIS				
☐ POLIOMYELITIS				
☐ COVID-19				VACCINE TYPE:
☐ MENINGITIS				
☐ BCG				
☐ Varicella (Chicken Pox)				
☐ TB Test	LIST TYPE (MANTOUX / TINE / OTHER):		IF TB TEST WAS POSITIVE, WAS CHEST X-RAY DONE? DATE:	

Doctor Signature

I, the undersigned, certify that a thorough physical examination of the applicant has been given and all important recent medical information has been included on the health certificate, that nothing relevant has been omitted, and that the applicant is able to travel. I understand that the omission of any information could be harmful to the applicant's health care and could result in early termination from the AFS program.

PHYSICIAN NAME AND DEGREE	SIGNATURE & STAMP
ADDRESS	DATE (DD/MM/YY)

Applicant and Parent/Guardian Signature

Your signature below attests that you understand and accept the AFS Medical Policies as stated on the Participation Agreement, that the information on the health certificate is correct and complete and that inaccurate or incomplete information could be harmful to the applicant's health care and could result in early termination from the AFS program.

APPLICANT SIGNATURE	DATE (DD/MM/YY)
PARENT/GUARDIAN SIGNATURE	DATE (DD/MM/YY)