FLEX 2025-26

TC 42001 504535

FORM M Student Health Certificate

INSTRUCTION TO THE STUDENT and NATURAL PARENTS:

This form must be filled out completely and accurately. The English language form must **BE FILLED OUT IN ENGLISH** and must contain all required stamps and signatures. If your doctor does not know English, your American Councils office will provide you with a local language form that the doctor can use. If the doctor fills out the local language form, return both that signed form, **AND** the translated, stamped, and signed English form along **WITH YOUR APPLICATION.**

A natural parent or legal guardian must complete and sign PART A, *after* PART B and PART C are completed. Your physician must complete **PART B**, and your dentist must complete **PART C**. After your health professionals complete Parts B and C, the student and parent must review the entire form to make sure nothing is missing. When you are certain that all parts of the form are **complete and correct,** sign and return it along with your application by the due date shown on **FORM 1.**

PART A, ACKNOWLEDGEMENT AND VERIFICATION: To be completed by the student's parent or legal guardian.

ACKNOWLEDGEMENT: I understand that:

- The program does not cover costs associated with pre-existing conditions, routine check-ups, dental work (including orthodonture), or glasses. Students and natural parents are solely responsible for these costs.
- If my child wears glasses and/or contact lenses I certify that they will bring an adequate supply for the program year.
- If dental work required for my child is not completed ***before*** they depart for the United States, I understand that I am responsible for any costs related to said dental work ***in*** the United States.

VERIFICATION: Is there any information about your child's physical, mental, or emotional health that is not on this form? **Mark one: YES ☐ NO ☐**

- If yes, please explain on a separate piece of paper and attach it to this form.

By signing this I acknowledge that I have read and understand the points above. I also certify that the information ***in or attached to*** this form is accurate and discloses **ALL** conditions and medications that I am aware of.

Student's Name: Kamolov (family name) Doniyor (first name) Fakhriddinovich (middle name) **Date of birth:** 15 / 11 / 2009 (DD MM YY) **Sex:** (M) F (circle one)

Parent's Name: Sobirov (family name) Fakhriddin (first name) **Parent's Signature:** SIGN _____ **Date of Signature:** 29 / 11 / 24 (DD MM YY)

PART B, MEDICAL CERTIFICATION: To be completed by the student's doctor.

1. MEDICAL HISTORY: Has the student ever received treatment, attention, or advice from a physician or other practitioner for, or been told by a physician or practitioner, that s/he had (check **YES** or **NO**):

	YES	NO
1.1 Asthma	☐	☑
1.2 Chronic or Recurrent Respiratory Disease	☐	☑
1.3 Rheumatic Fever	☐	☑
1.4 Disease or Abnormality of the Heart	☐	☑
1.5 High Blood Pressure	☐	☑
1.6 Chronic or Recurrent Upper Gastrointestinal Disorder	☐	☑
1.7 Chronic or Recurrent Lower Gastrointestinal Disorder	☐	☑
1.8 Enuresis (Bed wetting)	☐	☑
1.9 Chronic or Recurrent Kidney or Urinary Tract Disease	☐	☑
1.10 Persistent or Recurrent Headache	☐	☑
1.11 Seizure Disorder (Epilepsy)	☐	☑
1.12 Other Neurological Abnormality or Disease	☐	☑
1.13 Thyroid Abnormality or Disease	☐	☑
1.14 Diabetes Mellitus	☐	☑
1.15 Other Endocrine Abnormality or Disease	☐	☑
1.16 Chronic or Recurrent Arthritis	☐	☑
1.17 Muscle Disease or Skeletal Abnormality	☐	☑
1.18 Chronic or Recurrent Skin Condition	☐	☑
1.19 Cancer or Leukemia	☐	☑
1.20 Blood Disorder	☐	☑
1.21 Eye Abnormality or Disease	☐	☑
1.22 Hearing Impairment	☐	☑
1.23 Anorexia/Bulimia	☐	☑
1.24 Significant Weight Loss or Gain	☐	☑
1.25 Psychiatric Problem or Illness	☐	☑
1.26 Mental Health Concerns	☐	☑
1.27 Learning Disability	☐	☑
1.28 Reproductive System Abnormality or Disease	☐	☑
1.29 Sexually Transmitted Diseases	☐	☑
1.30 Tuberculosis	☐	☑
1.31 Hepatitis A	☐	☑
1.32 Hepatitis B	☐	☑
1.33 Hepatitis C	☐	☑
1.34 COVID-19	☐	☑
1.35 Measles	☐	☑
1.36 Mumps	☐	☑
1.37 Rubella	☐	☑
1.38 Other Childhood Diseases	☐	☑

Item No.	Date of most recent symptoms or attack	**If YES, is each condition: RESOLVED or ACTIVE** **If YES, provide:** ▪ diagnosis ▪ date of diagnosis ▪ duration of condition ▪ severity and frequency of condition ▪ treatment and medication plan ▪ how does it affect the patient's daily life? **Use additional paper if necessary.**
Example: *1.4*	*June 2023*	***Active:*** *Mitral valve prolapse, dx 2023, no strenuous sports but does not impact daily life. Needs yearly examination by cardiologist.*

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STUDENT NAME: Kamolov (family name) Doniyor (first name) Fakhriddinovich (middle name)

2. IMMUNIZATION RECORD. An accurate and complete record will be required for the student to enter school in the United States. All students must meet minimum U.S. school immunization requirements for Diphtheria, Tetanus, Pertussis, Poliomyelitis, Measles, Mumps, and Rubella. Record all dates (DAY/MONTH/YEAR) for all doses of the following vaccines that the student has received since birth.

2.1 Is there a medical reason the student cannot receive additional immunizations if required by a U.S. School? ☐ Yes ☑ No

If yes, explain: _____

Student date of birth: 15 | 11 | 2009 (DD MM YY)

	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
2.2 Diphtheria, Tetanus, and Pertussis (DTaP, DTP)	27 | 01 | 2010	26 | 03 | 2010	26 | 04 | 2010	19 | 04 | 2011	
2.3 Tdap (All students must receive a Pertussis vaccination AFTER October 1, 2016)					
2.4 Diphtheria and Tetanus (Td, Dt, TD)	07 | 06 | 2010	03 | 07 | 2010	26 | 10 | 2010	19 | 04 | 2011	25 | 05 | 2011
2.5 Poliomyelitis (All students must receive at least 4 doses. At least one dose must be given after age 4. Doses given before 6 weeks of age are invalid)	24 | 04 | 2012	23 | 05 | 2012	19 | XI | 2008	26 | 04 | 2010	
	27 | 04 | 2013	17 | 05 | 2010	21 | 05 | 2013		
2.6 Measles/Mumps/Rubella (MMR), **combination vaccine only** • *any dose invalid if given before age 1* • *if student received individual doses, indicate them in sections 2.15–2.16*	13 | 12 | 2010	29 | 01 | 2011	30 | 11 | 2015		
2.7a Varicella (**Vaccination**) **AND** **2.7b** Varicella (**History**)					
	Contracted disease? ☐ Yes ☑ No	if yes, when?			
2.8 Hepatitis A	15 | 02 | 2024				
2.9 Hepatitis B	15 | 11 | 2009	27 | 01 | 2010	26 | 03 | 2010		
2.10 Combination Hepatitis A and B					
2.11 Meningococcal (Conjugate or Serogroup B)					
2.12 Tuberculosis (BCG)	19 | 11 | 2009				
2.13 COVID-19 vaccination NAME: _____					
2.14 COVID-19 vaccination NAME: _____					
2.15 Other doses/Vaccinations NAME: _____ COMPONENT (if combination vaccine): _____					
2.16 Other doses/Vaccinations NAME: _____ COMPONENT (if combination vaccine): _____					

REQUIRED BY FLEX PROGRAM

REQUIRED BY U.S. SCHOOLS

STUDENT NAME: Kamolov Doniyor Fakhriddinovich
family name | first name | middle name

3. SCREENING FOR PULMONARY TUBERCULOSIS:
In order to enter school in the United States, it is required that the student be screened for tuberculosis.

3.1 TESTING: TB testing can be EITHER a Skin Test OR a Blood Test performed after **September 1, 2024.**

☐ **OPTION 1: TB Skin Test**
Results (Mantoux, PPD) must be read 48-72 hours after placement*

Date Placed:	DD MM YY
Date Read:	DD MM YY
# mm Induration:	____ millimeters

OR

☐ **OPTION 2: TB Blood Test **ATTACH LAB REPORT****
Results of QuantiFERON®–TB Gold or T–SPOT® TB test**

Check one:	☐ Negative ☐ Indeterminate ☐ Positive ☐ Borderline
Date of Test: ATTACH LAB REPORT	DD MM YY

** If the skin test result is 10mm or greater, provide the results of a current chest X-ray in #3.2 below.*

*** If the blood test result is positive, indeterminate or borderline, provide the results of a current chest X-ray in #3.2 below.*

3.2 CHEST X-RAY
A chest X-ray is necessary if: **A)** the skin test result is **10mm** or greater; **-OR-** **B)** the blood test result was **positive, indeterminate** or **borderline.**
The date of the normal chest X-ray must be on or after the date of the skin or blood test. Provide the results below:

Date of X-ray: DD MM YY **Chest X-ray result** (check one): ☐ **Normal** (-) ☐ **Abnormal** (+)

4. SYMPTOM REVIEW (mandatory):
Does the student currently have any of the following symptoms (check yes or no for each symptom)?

4.1 Persistent cough for more than two weeks:	☐ Yes ☑ No	**4.2** Fever or night sweats:	☐ Yes ☑ No	**4.3** Lymph gland enlargement:	☐ Yes ☑ No	**4.4** Bloody sputum:	☐ Yes ☑ No	**4.5** Recent or unexplained weight loss:	☐ Yes ☑ No	**4.6** Sharp chest pain when coughing:	☐ Yes ☑ No

4.7 If yes to any symptoms, a chest X-ray taken on or after the date of the TB skin or blood test must be provided below:

Date of X-ray: DD MM YY **Chest X-ray result** (check one): ☐ **Normal** (-) ☐ **Abnormal** (+)

5. PHYSICAL EXAMINATION:
Complete the following section based on your physical examination of the student.

Date of Examination: 29 | 11 | 2024 (DD MM YY)
Height (meters): 1,76 **Weight** (kilograms): 71
Blood Pressure (in mmHg): systolic: 120 diastolic: 80 **Pulse** (beats per minute): 78

PHYSICAL EXAM. Please indicate any **current** abnormalities of the following:

		NORMAL	ABNORMAL			NORMAL	ABNORMAL
5.1	Eyes (Mark ABNORMAL if vision loss is not correctable):	☑	☐	5.8	Urinary System:	☑	☐
5.2	Ears:	☑	☐	5.9	Thyroid Gland or Endocrine System:	☑	☐
5.3	Nose or Throat:	☑	☐	5.10	Reproductive System:	☑	☐
5.4	Lungs or Respiratory System:	☑	☐	5.11	Musculoskeletal System:	☑	☐
5.5	Heart or Cardiovascular System:	☑	☐	5.12	Brain or Nervous System:	☑	☐
5.6	Abdomen or Abdominal Organs:	☑	☐	5.13	Skin:	☑	☐

5.7 I certify that the student can participate in school sports: Yes ☑ No ☐ If no, explain: _____

Item No.	**If ABNORMAL, provide:** • diagnosis • date of diagnosis • recommended monitoring or treatment (including medications or surgery) • need for follow-up care • how does it affect the patient's daily life? **Use additional paper if necessary.**

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STUDENT NAME: Kamolov (family name) Doniyor (first name) Fakhriddinovich (middle name)

6. QUESTIONS FOR THE PHYSICIAN:

Check Yes or No box for each question. If "Yes," provide requested details in the second column. Use additional paper if necessary.

QUESTION:		IF ANSWER IS YES:
6.1 Has the student ever had surgery not revealed in previous questions?	☐Yes ☑No	Name(s) of surgery: Result of surgery: Date(s) of surgery (dd/mm/yy):
6.2 Has the student ever received inpatient care in a hospital, clinic, or sanatorium?	☐Yes ☑No	Dates of inpatient care (dd/mm/yy): Reason for inpatient care:
6.3 Has the student recently been advised to have surgery or additional medical care?	☐Yes ☑No	Name(s) of surgery needed: Type of additional care needed: Date(s) of surgery needed (dd/mm/yy):
6.4 Has the student taken any prescribed medication in the past 12 months?	☐Yes ☑No	For what condition: Name of medication(s) and dosage: *Will the student continue to take this prescribed medication in the U.S.?* ☐Yes ☐No
6.5 Will the student require routine medical monitoring or care while in the U.S.?	☐Yes ☑No	Monitoring for what condition(s): Frequency of monitoring: Type of monitoring:
6.6 Does the student have any limitations in physical activity?	☐Yes ☑No	Why? List the limitations:
6.7 Does the student have any allergies? If yes give name of <u>all</u> allergens.	☐Yes ☑No	☐ food: ☐ medicine: ☐ insect: ☐ other: **Type of allergic reaction:** ☐ anaphylaxis ☐ local reaction (describe): ☐ other (describe): **Response required:** ☐ none ☐ epinephrine auto-injector ☐ medication: ☐ other:
6.8 Has the student ever had anaphylaxis?	☐Yes ☑No	Date(s) (dd/mm/yy): Treatment: Cause:
6.9 Has the student ever had a head injury or traumatic brain injury (concussion)?	☐Yes ☑No	Date(s) (dd/mm/yy): Treatment: Cause:
6.10 Has the student ever (including now) had a speech problem (for example, speech impediment, lisp, or other)?	☐Yes ☑No	Name of diagnosis: Need for ongoing treatment: Date of diagnosis (dd/mm/yy): Current status:
6.11 Does the student have any dietary restrictions for health reasons (examples: gastritis, nut allergy)?	☐Yes ☑No	Reason/Condition: Excluded foods:
6.12 Is the student significantly overweight or underweight?	☐Yes ☑No	Reason/Condition: Treatment:
6.13 Has the student ever consulted a psychologist or psychiatrist?	☐Yes ☑No	Date of consultation(s): FROM: ______ (dd/mm/yy) TO: ______ (dd/mm/yy): Diagnosis:
6.14 Has the student ever abused alcohol, or drugs such as opiates or barbiturates?	☐Yes ☑No	Date(s) (dd/mm/yy): What: When last used?
6.15 Does the student wear glasses or contact lenses?	☐Yes ☑No	Check one: ☐ Glasses ☐ Contact lenses ☐ Both
6.16 Is there any medical reason why the student should not participate in this program?	☐Yes ☑No	Reason:
6.17 Has the student ever been tested for HIV?	☐Yes ☑No	Date(s) (dd/mm/yy): Result:
6.18 Has the student recently had COVID or complications from COVID infection?	☐Yes ☑No	**VIRAL TEST DATE** (dd/mm/yy): ______ Result: ☐ Positive ☐ Negative **ANTIBODY TEST DATE** (dd/mm/yy): ______ **Result:** ☐IgM positive ☐IgG positive ☐Both IgM & IgG positive ☐Negative

What is the general state of student's health? (check one): ☑ Excellent ☐ Good ☐ Poor

How long has this person been your patient? 1 Years ____ Months

If known less than a year, do you know the student's complete medical history? ☑Yes ☐No

PHYSICIAN NAME (first, last): ______

SIGN **PHYSICIAN SIGNATURE**: Шахмурадова Т.

DATE (dd/mm/yy): 28/XI 2024

STAMP

PART C. Dental Certification

To be completed by the student's dentist within the past year.

1.0 Are the student's teeth and gums in healthy condition? ☑ Yes ☐ No **DATE OF EXAMINATION:** 29.11.2024 DD/MM/YY

1.1 If no, explain in detail: ______

1.2 If dental work is needed, provide the date it was completed, or will be completed. **DATE:** ______ DD/MM/YY

2.0 The student wears: A) fixed braces? ☐Yes ☑No B) removable orthodontia devices? ☐Yes ☑No

2.1 If the student wears fixed braces, will they be removed before the student departs for the U.S.? ☐Yes ☐No ☑N/A

2.2 Is any follow-up required on fixed braces or orthodontia devices while in the U.S.? ☐Yes ☑No If yes, explain: ______

2.3 Will removable orthodontia devices be prescribed when the fixed braces are removed? ☐Yes ☑No

SIGN **DENTIST SIGNATURE**: [signature]

DATE (DD/MM/YY): 29.11.2024

DENTIST'S STAMP