Pan Atlantic Foundation

5. Statement of Applicant Health

Applicant Name: _____

Date of Examination: _____

Height: _____ Weight: _____ Blood Type (If known): _____

Physician must answer each of the following questions.

To be completed by attending physician. (Each of the following listed items MUST be checked "yes" or "no". Please do not leave any blank).

Has the applicant ever:

Had any of the following:	Yes	No	**Had any of the following:**	Yes	No	**Any disease, impair-ment, abnormality of:**	Yes	No
Allergies to Drugs	☐	☐	Hepatitis	☐	☐	Blood, Endocrine System	☐	☐
Food Allergies	☐	☐	Hernia	☐	☐	Bones, Joints, Locomotor System	☐	☐
Pet Allergies	☐	☐	Learning or Speech Defect	☐	☐	Brain, Nervous System	☐	☐
Smoke Allergies	☐	☐	Malaria	☐	☐	Digestive System/Abdominal Organs	☐	☐
Appendicitis	☐	☐	Measles (Rubeola)	☐	☐	Ears or Hearing	☐	☐
Asthma	☐	☐	Parasites (intestinal, other)	☐	☐	Eyes or Vision	☐	☐
Cough (persistent, recurring)	☐	☐	Rheumatic Fever	☐	☐	Genito-Urinary System	☐	☐
Diabetes	☐	☐	Rubella	☐	☐	Heart or Blood Vessels	☐	☐
Eating Disorder	☐	☐	Scarlet Fever	☐	☐	Respiratory System, Lungs	☐	☐
Enuresis	☐	☐	Seizure Disorder	☐	☐	Skin (Acne, etc.)	☐	☐
Goiter (Struma)	☐	☐	Sleepwalking	☐	☐	Tonsils, Nose, or Throat	☐	☐
Headache (persistent)	☐	☐	Vertigo, Dizziness	☐	☐	Varicose Veins	☐	☐

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Applicant name: _____

If "Yes", was checked for any of the above, physician must provide full details and dates of treatment:

_____

Please indicate any other pertinent medical information that may have been omitted. (Such as abnormal blood pressure, weight problems, etc.)

_____

To be completed by attending physician. (Each of the following listed items MUST be circled "yes" or "no". Please do not leave any blank).

Has student ever been hospitalized? ☐ Yes ☐ No
If yes, please provide date and reason: _____

Has the applicant ever been had surgery? ☐ Yes ☐ No
If yes, please provide date and reason: _____

Has applicant ever been advised to have surgery which has not been done? ☐ Yes ☐ No
If yes, please provide date and reason: _____

Has applicant ever consulted a neurologist, psychiatrist, psychologist, or any other specialist in nervous or emotional disorders? ☐ Yes ☐ No
If yes, please complete Health Addendum.

When and for what reason did the student last consult a physician? _____

_____

Should the student be restricted from any type of physical activity? ☐ Yes ☐ No
If yes, please explain: _____

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Applicant Name: _____

What diseases, ailments, or injuries has the student had in the last year?

_____

Allergy: _____ Mild ☐ Moderate ☐ Severe ☐

Treatment required: _____

Allergy: _____ Mild ☐ Moderate ☐ Severe ☐

Treatment required: _____

Allergy: _____ Mild ☐ Moderate ☐ Severe ☐

Treatment required: _____

To be completed by attending physician, not applicant or family member.

Please indicate any medication the applicant is currently taking and the purpose of using these drugs. (Note: when applicant studies abroad, a supply of medication should be provided in clearly labeled containers indicating the drug's generic name.)

Medication: _____ Purpose: _____ Dosage: _____
Student will take in U.S.? Yes ☐ No ☐

Medication: _____ Purpose: _____ Dosage: _____
Student will take in U.S.? Yes ☐ No ☐

Medication: _____ Purpose: _____ Dosage: _____
Student will take in U.S.? Yes ☐ No ☐

If there are any drugs (prescription or nonprescription) that should not be administered, please list them here.

_____

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Applicant Name: _____

IMMUNIZATION RECORD

Pupils enrolled in kindergarten through grade 12 in the US are required to have written proof on file at their public or nonpublic school that they have been immunized against DTP (diphtheria, tetanus, pertussis), poliomyelitis, measles, mumps, rubella, and hepatitis B. Failure to do so is cause for exclusion from school. Additional immunizations requirements vary by state and student may also need to provide written proof of Hepatitis A and Meningococcal vaccinations.

Please indicate the vaccine and date each dose was given. Do not use brackets ({,}) or quotation marks (“) to complete the chart—each vaccination date must be written out in the space provided in month/day/year format.

Date Of Birth: Vaccine	1st Dose mm/dd/yyyy	2nd Dose mm/dd/yyyy	3rd Dose mm/dd/yyyy	4th Dose mm/dd/yyyy	Most Recent * Dose mm/dd/yyyy
Polio (IPV) Three, four or five doses of polio (IPV) vaccine **					
Hepatitis B (3 doses)					
Four or five doses of diphtheria-tetanus- pertussis (DTaP) vaccine * One dose of tetanus-diphtheria-pertussis (Tdap) vaccine in grades seven through twelve					

*The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.

** If four or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least six months after the previous dose. A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least six months after the previous dose.

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Applicant
Name:_____

Vaccine	1st Dose mm/dd/yyyy	2nd Dose mm/dd/yyyy	Most Recent mm/dd/yyyy	OR	Date of Illness mm/dd/yyyy
Measles (rubeola—10 day, red measles) two doses, or physician-verified disease				OR	
Rubella (German measles—3 day, measles) two doses, or physician-verified disease				OR	
Mumps (two doses, or physician-verified disease)				OR	
+Chicken Pox (Varicella) (2 doses or date of disease)				OR	
Hepatitis A (state dependent)				OR	
Meningococcal (state dependent)				OR	
Covid Vaccine					

† Varicella vaccine is not required if varicella disease is documented by the health care provider.

	Result (+ or -)	Date Administered	Date Results Read		
Tuberculin skin test					
	Result (+ or-)	Date of X-ray			
If positive, report of negative X-ray & copy required					

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Applicant Name _____

Please check your opinion of the state of the candidate's health:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

I, the undersigned, have reviewed the medical history of the applicant and given a thorough physical examination, certify that all important medical information has been noted on this form and that nothing relevant has been omitted, and state that I am not a family relation of the applicant examined.

Physician's Name (printed) : _____

Physician's Signature: _____

Physician's Address: _____

_____

_____

Date (mm/dd/yyyy): _____

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