Medical History Questionnaire

Student: Please complete the first two pages of this form before your appointment with a physician. The Physical Exam and Health Clearance Form (page 3) must be signed by the examining physician and be submitted to the AJY program.

Physician: Please review pages 1-2 with the student and complete page 3 of this form to indicate whether the student has been cleared for studying abroad in Heidelberg, Germany. Living and studying in a foreign environment frequently creates unexpected physical and emotional stress, which can exacerbate otherwise mild conditions. Please note that:

- The student must present you with a fully completed Medical History Questionnaire. Please review for accuracy and completeness.
- Special attention should be paid to any emotional or psychological conditions, treatments, and medications (which may not be available abroad).
- Physical and learning disabilities should be noted on the form, along with indications of required accommodations so the AJY program can start making possible arrangements on site.

Student's Name _____
Last First Middle

Preferred pronouns _____ **Birth Date** (MM/DD/YYYY) _____

Place of Birth (City, State, Country) _____

Home Address _____

_____

Primary Physician _____

Phone #_____

Emergency Contact _____
Name Phone # Email

In planning the program, AJY staff makes decisions about things like housing (e.g., host family placement), excursions (including walking tours), food, etc. Please make us aware of conditions or preferences so we can make the proper accommodations:

Dietary restrictions & preferences: _____

Readiness for walking tours & short hikes: _____

Allergies: _____

Current medications & prescriptions: _____

_____

Relevant Medical History (including mental health*): _____

_____

_____

_____

*While emergency psychiatric services are readily available in Heidelberg, regular psychiatric counselling is harder to provide on short notice. If you are receiving regular treatment, it may be worth ensuring continuity through virtual appointments.

Immunization Record

(**) Please note that the immunization record below must be completed in its entirety.

**M.M.R. (Measles, Mumps, Rubella) (Two doses REQUIRED after 12 months of age-need childhood dates)	_____ M D Y	_____ M D Y			
**TETANUS-DIPHTHERIA IMMUNIZATION (Include childhood dates and at least 1 booster date within past 9 years- REQUIREMENT)	#1 _____ M D Y	DTaP/DPT #2 _____ M D Y	DTaP/DPT #3 _____ M D Y	DTaP/DPT #4 _____ M D Y	**Tetanus Td/TDaP Booster (most recent booster must be within the past 9 years) ____/___/_____ M D Y
**POLIO IMMUNIZATION (Primary series in childhood meets REQUIREMENT).	OPV #1 _____ M D Y	OPV #2 _____ M D Y	OPV #3 _____ M D Y	OPV #4 _____ M D Y	
**CHICKEN POX History of chicken pox disease, positive antibody test OR documented vaccination dates meet the REQUIREMENT.	History of Disease Yes or No Age of disease _____ yrs. old	Positive Antibody Titer Y or N _____ M D Y	Date of Vaccine (If no history of disease) #1 _____ M D Y	Date of Vaccine #2 _____ M D Y	
**HEPATITIS B (3) doses meet the REQUIREMENT.	#1_____ M D Y	#2 _____ M D Y	#3 _____ M D Y		
**TUBERCULIN SCREEN & MANTOUX TEST REQUIREMENT	Have you ever had close contact with anyone who was sick with TB? Yes / No	Were you born or have you traveled to a country with a high rate of TB? Yes / No If yes, where? _____	Have you been vaccinated with BCG in an international country? Yes / No	Have you ever had a positive TB skin test? Yes / No	**Tuberculin (PPD-MantouxTest) Date Given _____/_____/____ Date Read _____/_____/_____ Results _____mm Neg./Pos
MENINGOCOCCAL MENINGITIS A, C, Y, W-135 (STRONGLY RECOMMENDED)	Menactra or Menomune _____ M D Y				

I hereby certify that all information I have provided is true and correct to the best of my knowledge.

_____ _____

Student Signature **Date**

Physical Exam and Health Clearance Form

CLEARANCE

- ☐ Cleared **without restriction** for study abroad with the American Junior Year Program.
- ☐ Cleared, **with restrictions** or recommendations for further evaluation/treatment. Please elaborate:

  _____

  _____

  _____

- ☐ **Not cleared for Study Abroad.** Please elaborate: _____

  _____

  _____

SIGNATURE

For what length of time have you treated the student? _____

Printed name of Physician: _____

Signature of Physician: _____

Date