

**J1 SUMMER WORK TRAVEL PROGRAM**  
**Health Screening (To be completed by participant)**



\_\_\_\_\_  
 Last Name First Name Date of Birth (MM/DD/YYYY)

**Gender:** Male Female **Height:** \_\_\_\_\_ (in feet and inches) **Weight:** \_\_\_\_\_ (in pounds)

**General Health Questions:** If you answer "Yes" to any of these general health questions please give full details on a separate sheet of paper.

Is your physical activity restricted in any way? Yes No Do you have any dietary restrictions? Yes No  
 Do you have a chronic or recurring illness? Yes No Are you currently taking any medications? Yes No  
 Have you ever been treated by a psychiatrist? Yes No Have you ever undergone surgery? Yes No  
 Have you ever received treatment for a nervous or emotional issue? Yes No

**Health History** (Check all that apply)

Anemia	Dizziness/Fainting	Heart Disease	Mumps
Anorexia	Ear Infection	Hepatitis A/B/C	Pregnancy
Arthritis	Epilepsy/ Seizures	Kidney Disease	Rheumatic Fever
Asthma	Eye Problems	Malaria	Scarlet Fever
Bulimia	Gallbladder Problems	Measles	Tuberculosis
Chicken Pox	German Measles	Menstrual Problems	Ulcers
Depression	Glandular Fever	Migraine/ Headaches	Venereal Disease
Diabetes	Other		

If you check any of the above, please give details (including dates) on a separate sheet of paper.

**Abnormalities of Organs or Systems** (Check all that apply)

Cardiovascular	Head, ears nose, throat	Reproductive	Metabolic
Respiratory	Eyes (including glasses or contacts)	Gastrointestinal	Skin
Genitourinary	Musculoskeletal	Nervous	Other

If you check any of the above, please give details (including dates) on a separate sheet of paper.

**Allergies** (Check all that apply)

Allergies	Describe reaction:	Management or treatment:
Hay Fever		
Insect Sting		
Penicillin		
Other drugs		
Other:		

**Insurance Information:**

If you are a US citizen, F1 OR a J1 participant covered by a **different** insurance than that provided by your sponsor, please give details:

Carrier Name: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Carrier/Plan Number: \_\_\_\_\_ Group or Policy Number: \_\_\_\_\_

**Emergency Contact \*\*Must speak English\*\***

Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

I certify that all information given is true to the best of my knowledge, and I hereby give permission for emergency medical care should it be necessary.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date (MM/DD/YYYY)

**J1 SUMMER WORK TRAVEL PROGRAM**

**Health Screening (To be completed by physician)**



\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Date of Birth (MM/DD/YYYY)

As an exchange visitor participant, the above named student will be traveling abroad with the intention of interacting with and potentially living with American citizens as an ambassador of his/her home country. As part of the program, the participant is permitted to and/or expected to work to offset travel and program costs. It is therefore important that we are advised of any physical or mental health problems that may have a bearing on the applicant's ability to accept such responsibilities.

Please review the information provided by the applicant on Page 1 of this form and answer the following questions. (Circle One)

*The above named applicant is in good physical condition.*

Correct

Incorrect

*The above named applicant does NOT have any physical issues that might negatively affect or hinder his/her ability to work.*

Correct

Incorrect

*The above named applicant does NOT have any emotional issues that might negatively affect or hinder his/her ability to work or to socially interact and/or reside with American citizens.*

Correct

Incorrect

**Other Comments:**

Please check whether the applicant had been immunized against the following and provide the date of immunization:

<b>Measles</b> Date	<b>Mumps</b> Date	<b>Rubella (German Measles)</b> Date	<b>Meningococcal Meningitis - MCV4</b> Date
<b>Diphtheria</b> Date	<b>Tetanus</b> Date	<b>Pertussis</b> Date	<b>Varicella (Chicken Pox)</b> Date
<b>Hepatitis B</b> Date	Hepatitis A Date	Polio – IPV Date	HIB Haemophilus Influenzae Type B Date
Rotavirus Date	Pneumococcal Conjugate – PVC 13 Date	Tdap – 10 year Booster Date	Whooping Cough Date
TB Mantoux test Date	H1N1 – Swine Flu Date	Most current Flu Shot Date	Typhoid Date

\_\_\_\_\_  
Signature of Licensed Medical Personnel

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Printed Name of Licensed Medical Personnel

\_\_\_\_\_  
Title

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Email