7242 La Jolla Blvd
La Jolla, California 92037

Telephone: (858) 455-0302
Fax: (858) 455-0335
www.afice.org

afice
Academic Foundation *for*
International Cultural Exchange

A non-profit tax exempt educational Foundation

CERTIFICATE OF HEALTH

(Please Type or Print)

Year Student ☐
Semester Student ☐

Student's Name _____
Last First Middle

Home Address _____
Street Postal Zone City Country

Telephone Number _____/_____
Area Code

Date of Birth _____/_____/_____
Month Day Year

TO BE COMPLETED BY A MEDICAL DOCTOR

Has the applicant suffered from any of the following? Indicate by checking the box in the appropriate column for YES or NO.

	Yes	No		Yes	No
Allergies	☐	☐	Malaria	☐	☐
Appendicitis	☐	☐	Pneumonia	☐	☐
Has his/her appendix been removed?	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Scarlet Fever	☐	☐
Cancer Tumors	☐	☐	Tuberculosis	☐	☐
Chicken Pox	☐	☐	Typhoid Fever	☐	☐
Convulsive Disorders	☐	☐	Thyroid Disease	☐	☐
Diabetes	☐	☐	Serious or Persistent Cough	☐	☐
Epilepsy	☐	☐	Serious or Persistent Headache	☐	☐
German Measles	☐	☐	Migraine	☐	☐
Hepatitis	☐	☐	Ulcer	☐	☐
Hernia	☐	☐	Vertigo, Dizziness	☐	☐
Has he/she been operated for hernia?	☐	☐			
If yes, successful?	☐	☐			

Any disease, impairment, or abnormality of:

Eyes or Sight	☐	☐	Other Abdominal Organs (Liver, Kidney, etc.)	☐	☐
Ears or Hearing	☐	☐	Skin (Acne, etc.)	☐	☐
Tonsils, Nose or Throat	☐	☐	Lungs, Respiratory System	☐	☐
Have his/her tonsils been removed?	☐	☐	Brain or Nervous System	☐	☐
Stomach or Digestive System	☐	☐	Blood or Endocrine System	☐	☐
Genito-Urinary System	☐	☐	Other	☐	☐
Heart or Blood Vessels	☐	☐			

Height _____ Weight _____

Pulse rate _____ Is pulse rhythm normal? _____

Blood pressure: Systolic _____ Diastolic _____

Are pupillary and knee reflexes normal? _____

What is the applicant's vision: Without eyeglasses? OD _____ OS _____

With eyeglasses? OD _____ OS _____

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Please give full information (including dates and details) about every disease or impairment mentioned in any of the questions on the first page.

_____

_____

Has the applicant ever been hospitalized? Yes ☐ No ☐

If yes, please give date, diagnosis and outcome of each illness or accident _____

_____

_____

Is the applicant currently taking any oral medication? Yes ☐ No ☐ Injected medication Yes ☐ No ☐ Other medication Yes ☐ No ☐

If yes, please give name(s) of medication(s), diagnosis and indicate when treatment will be discontinued _____

_____

Does the applicant have a history or present evidence of nervous, emotional or mental abnormality? For example, is there any history of enuresis, nervous breakdown, nervous fatigue, recurrent nightmares, sleepwalking, stammering, stuttering or other similar conditions? Yes ☐ No ☐

If yes, please give details and current status _____

_____

Does the applicant have a history or present evidence of any emotional or eating disorder? Yes ☐ No ☐

If yes, please give details and current status _____

_____

Has the applicant ever consulted a neurologist, psychiatrist, psychologist or any other specialist in nervous or emotional or eating disorders? Yes ☐ No ☐

If yes, please give details _____

_____

Does the applicant have any health limitations or do you know of any pertinent medical information which is important for AFICE to know should the applicant be considered for placement abroad? Yes ☐ No ☐

If yes, please comment fully _____

_____

Will the applicant need any orthodontic care during the coming year? Yes ☐ No ☐

If yes, attach a statement from the orthodontists, indicating present status, exact care essential to the orthodonture and date care will be completed.

Has the applicant any history or present evidence of any allergy? Yes ☐ No ☐

Type of allergy (e.g. eczema, hives, hay fever, asthma or other) _____

_____

Allergen (food, drug, pollen or other) if known _____

Frequency of symptoms _____

Duration of symptoms (hours? days?) _____

When were the last symptoms (month and year)? _____

Describe symptoms in detail and indicate severity _____

_____

_____

_____

Have the allergic symptoms ever interfered with the patient's ordinary activities at home or at school? Please give details and dates.

_____

_____

_____

In the past year has the applicant received for the allergy (ies):

a) injected medications (give names, dosages and dates) _____

_____

b) oral medications (give names, dosages and dates) _____

_____

Please indicate any treatment for allergy (ies) expected during the coming two years by means of:

a) injected medications? (give names, anticipated dosages and dates)

_____

_____

b) oral medications? (give names, anticipated dosages and dates)

_____

_____

Has the applicant had asthma? (if so, give details and dates) _____

_____

When will allergy treatment and medication be entirely discontinued?

_____

How long has the applicant been your patient? _____

In my opinion the general state of applicant's health is: (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments: _____

_____

_____ _____
Name of Physician (Type or Print) Degree

_____ _____/_____/_____
Address Street Date of Examination Month Day Year

_____
Postal Zone City Country

IMMUNIZATIONS: The following Immunizations are the *MINIMUM* required for acceptance into the AFICE program. Depending on a particular State or School, additional vaccines may be required. The student will be fully responsible for paying out of pocket for any additional immunizations that are required, and will not be considered or accepted onto the AFICE program without the completed requirements as listed here at the time of application to the AFICE program. Physician must list the age of student at time of vaccine.

POLIO – 3 doses required if 3rd dose was administered on or after 4th birthday – otherwise 4th dose required

_____ ____ _____ ____ _____ ____ _____ ____
Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age

DTP – (Diphtheria, Tetanus, Pertussis) – 4 doses required if at least 1 dose was administered after the age of 4. Additional dose will be required if last vaccine was administered on or after 2nd birthday

_____ ____ _____ ____ _____ ____ _____ ____
Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age

Tdap Booster (Tetanus, reduced diphtheria and pertussis) – 1 dose administered after age 13

_____ ____
Month/Day/Year Age

MENINGOCOCCAL – 1 dose required between the ages of 13 – 17

_____ ____
Month/Day/Year Age

HEPATITIS B
3 doses required

_____ ____ _____ ____ _____ ____
Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age

MEASLES (Rubeola) – 2 doses required, beginning on or after 1st birthday (part of MMR Vaccine)

_____ ____ _____ ____ Or, Date of Disease: _____ ____
Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age

MUMPS – 2 doses required, beginning on or after 1st birthday (part of MMR Vaccine)

_____ ____ _____ ____ Or, Date of Disease: _____ ____
Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age

RUEBELLA – 2 doses required, beginning on or after 1st birthday (part of MMR Vaccine)

_____ ____ _____ ____ Or, Date of Disease: _____ ____
Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age

VARICELLA (Chicken Pox) – 1 dose minimum required – 2nd dose required between the ages of 13-17

_____ ____ _____ ____ Or, Date of Disease: _____ ____
Month/Day/Year Age Month/Day/Year Age Month/Day/Year Age

TB TEST

Results: + / - (Circle One) Date: _____ Month / Day / Year Results: _____

Has the student ever had a BCG vaccine for Tuberculosis? Yes _____ Date: _____ Month / Day / Year No _____

Has the student ever had a chest X-ray? Yes _____ Date: _____ Month / Day / Year No _____ Result: _____

WE HEREBY CERTIFY THAT THE INFORMATION GIVEN IN THIS IMMUNIZATION CERTIFICATE IS COMPLETE AND ACCURATE TO THE BEST OF OUR KNOWLEDGE AND BELIEF

_____ _____/_____/_____
Signature of Physician Name of Physician (print or type) Month Day Year

_____
Address of Physician's office or clinic